			For	State of Ma	-	partment of He			000	1 2	2000
	_		Registrar 1. Decedent's Name (First, Middle, L.	net)		- Lincale Of L	- Calli	2. Date of Dea	leg. No.	4	3. Time of Death
	Physici	an	1. Decedent's Name (Pilst, Middle, L.	DA.				Month	Day Y	ear	630 A M
100	/Medic		4a. Facility Name (If not institution, gi	o street and number)		4b. City, Town, or	Location of Death	UCT	4c. County of		D- 4
	Examin	er	A 1			120			40. County of	Dodui	
				SP1774L.	e (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	1 9	. Birtholac	e (State or Foreign
н	Funeral Director			1□M 2🌠 F	68 Yrs.	Months Davs	Hours Min.	8. Date of Birth (Month, Day June 28	, Year) 1936	Country	unk
			Usual Residence of Decedent					oune 20	, 1000		
	yland		10a. State 10b. County MD		10c. City, Town or					10d	. Inside City Limits
	a-f.	cto	FID		Baltin	nore					1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country	?
	23a ust b		524 N. Charles				1201		US		
	eems.	Funerai	11. Marital Status un	12. Was Decedent Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	American White, etc	
36	or II	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ N	o unk	1 ☐ Yes 2 🌠 No	Specify:		Specify:	wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tha Mudical Excining must be notified at		3 Widowed 4 Divorced	Year or Dates:	162 Do	cedent's Usual Occupa	tion	1177	16b. Kind of Busi		
15	"nat	Completed	15. Decedent's I (Specify only highest g		(G.	ive kind of work done do b. DO NOT use retired)	uring most of work	ing unk	100. Kind of Busi	11622/11/023	stry unk
12	withi ene. than	m.	Elementary/Secondary (0-12) unk	College (1-4or 5	+)	,					
9	filed withi Hygiene. other than		17. Father's Name (First, Middle, Las			unk	18. Mother's Name	e (First, Middle,	Maiden Sumame)		unk
lan	ld be ental ked c	To Be									
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 is marked other than "neturati, or Items 23e or 28e-f show item 27 is marked other than "neturati, or Items 23e or 28e-f show other traumatic event, Ite Mudical Examination matter and the mailined at	H	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ailing Address (Street a	nd Number or Rur	al Route Numbe	r, City or Town, St	ate, Zip Co	ode)
Š	nd 2 lith ai 27 is	H.	Mercy Hospital		3	01 St. Paul	Place	Baltimo	re. MD	21202	
ē,	item 27	1	20a. Method of Disposition		20b. Place of Dis	sposition (Name of trematory or other place	1	Date	20c. Location - Ci		n, State
100			1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ※ Other (Spec		Cometery, C	remaiory or other place	_ !				
Baltimore,			21. Signatura of Funeral Service Lice			22. Name and Address	s of Facility				
B	permit. Departr Importa any inju		Ronald S.	Wade	ctor	State Anato Baltimore,	my Board	1655 W.	Baltimo	re St	reet
		4	23a. Part1. Enter the disease, or co	mplications that caused	the death. Do not			or respiratory ar	rest,	A	pproximate iterval Between
			shock, or heart failure. List on Immediate Cause (Final	y one cause on each li		HDRONE					nset and Death
a	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as	a consequence of):	~DRONE					ice
в	Examiner			KIA	SIFLA	URINARY	INF	ECTION)		40
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of,			7			
	uted d ansit	Examin	it arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
ó	exec an an rial-tr		resulting in death) Last	Due to (or as	a consequence of):						
8760,	sate be executed obysician and the burial-transit	dicai		d							
9	The law requires that the death certificate be executed the has been signed by the attending physician and otge 2 should be detached for use as the burial-transit	ledi									
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 ☐Ectopic pregnancy			23d. Date		Wass
	death	sicle	in the past 12 months? 1 ☐ Yes 2 No	4☐ Pregnant at 9☐ Unknown		5 Other (specify)			Month	n Da	ay Year
P.0	at the de by the stached	hys	9 Unknown					Τ			
	res tha igned be det	by F	Part II. Other significant conditions	contributing to death b	ut not resulting in the	a underlying cause give	n in Part I.		bacco use contrib		
ord	w requir been si should	ted						1 1	′es 2 □ No 3	☐ Probab	ly 452 Unknown
Records,	lawr as be 2 sh	pie						24a. Was autop			y findings available letion of cause of
ď	The Tate has page	Completed						perfor 1 ☐ Yes	med? dea	ath?]Yes 2[□ No
Vital	ian: Thi	Be C	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	ne)		
of <	Physician: this certific ral director,	2	1 ☐ Yes 2 (Deta)o	Hospital:	ent 2 ER/Outpa	- Inches	4 INDISHING FIG	me 5 Resid	ence 6 Other	(Specify)	
		ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Ye <i>ar)</i> Injui		at ?	28d. Describe h	ow injury occurred		
0	Vitendi death. ctor: A y the fu	atie	2 Accident investigat			M 1 🗆 Y	′es 2 □ No				
Division		Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Ini building, et	ury - At home, farm, c. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tox	itreet and Number m, State)	or Rural F	Route Number,
	ital cars af										
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in Director C	Medical		Physician: To the best aminer: On the basis o and manner st	f examination and/o						
	o the	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (
	r s r ŏ		J-AC	=6 MD		D4	2634		OCT -	3. 7	2004
			30. Name and ad vess of person wh	o completed cause of a	leath (Item 23a) (Tu	ne. Print)		W 7 1	WX		
				STA NO		ST PALL	PLACE	BACT	OCT -	41)	20215
	St	atė	31. Date filed (Month, Day, Year)	2/1/	ar's Signature						
	Regist		OCT 1 4 2004	Serv	a B	Sparks					

			1 - For State Registrar	State of Man		artment of He		ental Hygien	2001	32502
			Decedent's Name (First, Middle, Last	Ų			1	2. Date of Death		3. Time of Death
	Physici		Leola L) quis				Month	Year Year	
	/Medic Examin		4a Eacility Name (If not institution, give			4b. City, Town, or L	ocation of Death	4	c. County of Dea	ath
1	LXamin		Bon Scoon	& Hass	y tal	Balt	yamı,		Baltim	ne Gly
	Funeral		5. Social Security Number 6. Se	7. Age (/	n yrs. last birthday)		If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Yea	9. Bi	irthplace (State or Foreign
	Director		212-28-3220	⊒M 2ŽŽX.	78 Yrs.	Months Days	Hours Min.	JUNE 6, 1	926 S	Country) OUTH CAROLINA
	۵ .		Usual Residence of Decedent		- O'L T					
	arylar shov	<u>_</u>	10a. State 10b. County		0c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	cto	MARYLAND N/A		BALTIMO					
	ith tt	Director	10e. Street and Number			10f. Zip Code		10g. C	Citizen of What C	country?
	ath v		916 S. BRUNSWICE			21223			U.S.A.	
	er de	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Am Black, Wh	
36	hours after death with the Maryland turet, or Items 23a or 28a-f show al Examinat munt be rediffed at	by F	1 ☐ Never Married 2 ☐ Married 3XXVidowed 4 ☐ Divorced	1 ☐ Yes 2 XX No If Yes, Give Year or Dates:		1 ☐ Yes 2ĀĀNo	Specify:		Specify:BLA	ACK
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "naturelt, or Items 23a or 28a-f show of other the Medical Examinat must be notified at	edit	15. Decedent's Edu		16a, Dece	dent's Usual Occupation	on	16h	Kind of Busines	
5	in 72	Completed	(Specify only highest grad	de completed)	(Give	kind of work done dur DO NOT use retired)	ring most of working	7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
72	within lene.	шo	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)	קיד	AM LEADER		МО	NTGOMERY	V WARD
D	e filed within al Hygiene. other then ' vant, 'be we	ا به ا	17. Father's Name (First, Middle, Last)				8. Mother's Name (First, Middle, Maide		1111111
Maryland	2 should be and Mental la marked o	To B	JAMES W SHANNON				ALEXANDI	RA PATE		
ary	s 1 and 2 should f Health and Mer item 27 ia marke other traumatic	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ng Address (Street and	d Number or Rural	Route Number, City	or Town, State,	Zip Code)
			Franklin Davis/So	on	916	S. Brunsw	ick St.	Balto. M	d. 2122:	3
e,	ss 1 and 2 of Health item 27 i	1 3	20a. Method of Disposition		20b. Place of Dispo		Da		Location - City o	
E	Page nent c		1 ØBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		-	CEMETERY	10-14-	-04 LAN	DSDOWNE	MARYLAND
Baltimore,	permit. Pages : Department of h Important: If ite any injury or ot		21. Signature of Program Salver & Signature		2:	2. Name and Address	of Facility			
Ö	Depar Impo			Hour		ILLIAM C B 206 W NORT		MONTLA F.O.	NERAL HO	OME P.A.
	10		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the				respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Pinon					Onset and Death
	/Medical		resulting in death)	a.	onsequence of):					1
В	Examiner		Convention lies conditions	m La	and and	Q A DIMO	2			
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a c	onsequence of	(\			
	cuted	Exam	that initiated events	V.	car gr	. I witc	TATIL			
0,	death certificate be executed e attending physician and nd for use as the burial-transit	Ä	resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	sate be ex physician the buria	dlcal		d						
9	artific ing p	0	IF FEMALE:							
Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 [Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
0	it the dez by the a tached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□ Unknown	ne of death 5[Other (specify)			TOTAL T	ouy
<u>P</u> .	that the		Part II. Other significant conditions co	entributing to doub but a	not reculting in the u	adorhija osuco avos	in Part I	23a Did tobacco	s use contribute	to the cause of death?
S,	Se Ded	by	Part II. Other significant conditions co	intributing to death but i	iot resulting in the t	indenying cause given	III Faiti.	1 Tes		Probably 4 Munknown
oro	w requir been si should	ted						10,163	-	
Records,	2 2 2	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
三田		Cor						performed?	death? lo 1 ☐ Ye	s 2 No
Vital	aician: certifical rector, p	Be	25. Was case referred to medical examiner?	Haspital:			6. Place of Death (Check only one)		
of	03 (r) =	2	1 1 105 275 110	Hospital: 1 Inpatient	2 ER/Outpatie		4 Nuising Home	e 5 Residence		ecity)
n	ling I I. After funer	o	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	Work?	s 2 □No	d. Describe how inj	ury occurred	
Sic	Attanding r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		At home form at			If Location (Street	and Number or E	Rural Route Number,
Division		Certification:	4 ☐ Homicide determined	building, etc. (Specify)	eet, factory, office	20	City or Town, Sta		idiai i iodio i valinoci,
_	Hospital Hospital Hours a Funerel Holy filled		29a. Certifier 1 Certifying Phy	ysician: To the best of n	ny kaowiedae deat	h occurred at the time	date and place, an	d due to the cause	(c) and manner s	e etated
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	(Check only 2 Medical Examone)	iner: On the basis of ex	amination and/or in	vestigation, in my opin	ion, death occurred	at the time, date a	nd place, and du	e to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	7		29c. License n	number	29d. D	ate signed (Mon	th, Day, Year)
	->-0					D006	6292	10	101-	1
-	Λ		30. Name and address of person who	ompleted cause of dear	h (Item 23a) (Tvna		212		11/00	1
	7		Bon Seco	1-La	FRA tal	Balton	nore, M	y		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's		11	(-	/		
	Registi	ar	Wel. 142	004 Bens	D	spork	red .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22502 Certificate of Death

		- 1	State Registrar		erti	ficate of L	Jeani			No.	3. Time of Death
			Decedent's Name (First, Middle, Last)			DAVIDO	ON		te of Death	1 ⁰ 0, 200 ⁵	
	Physicia /Medic	al la	RUTH	E		DAVIDS			UDER	4c. County of E	
	Examine		4a. Facility Name (If not institution, give street and number)		4	lb. City, Town, or	NT AI			40. County or a	FREDERICK
			4937 OLD BARTHOLOWS ROAD	e (In yrs. last birth	day)	If Under 1 Year	If Under	24 Hrs. R Da	te of Birth	9.	Birthplace (State or Foreign Country)
	Funeral		5. Social Security Hermosi	70 Yr		Months Days	Hours	Min. JUL	27,1	934	MD
	Director	-	214-34-2713 Usual Residence of Decedent	70							10d. Inside City Limits
	land	Ì	10a. State 10b. County	10c. City, Town	or Loca	ition					1 ☐ Yes 2 ☑ No
	Mary -1 eh	ţ	MD WORCESTER	В	ERL	IN					
	1 the	rec	10e. Street and Number			10f. Zip Code			109	g. Citizen of Wha	
	death with the Maryland ms 23a or 28e-f ehow r must be rollfied at	a D	12508 OCEAN REEF DRIVE				218		os or No	US.	American Indian,
	deat	Funeral Director	11. Marital Status 12. Was Decedent Armed Forces		13. W	as Decedent of H Yes, specify Cuba	ispanic Or an, Mexicai	n, Puerto Rican	etc.)	Black,	White, etc.
٥	illed within 72 hours after death with the Marylan Hygiene. uther then "natural", or Items 23a or 28e-1 ehow uther then "natural", or Items The rottified ut	E	1 ☐ Never Married 2 (X) Married 1 ☐ Yes 2 (X) If Yes, Give Year or Dates:	No	1 (☐ Yes 21X No	Specify:	:		Specify:	WHITE
315-UU36	urai',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. I	Decede	ent's Usual Occup	ation	a of considering	1	6b. Kind of Busin	ness/industry
γ̈	"nat	Completed	(Specify only highest grade completed)		(Give k lite. D	ind of work done O NOT use retired	auring mos d)	st of working			CONCRECATION
212	withii ene. then	Ę.	Elementary/Secondary (0-12) College (1-40r	SE	CRE	TARY					CONGREGATION
2	tiled wil Hygien other th	BeC	17. Father's Name (First, Middle, Last)						t, Middle, M	laiden Sumame)	BASHOFF
<u>a</u> n	o a b	To B	FRANK		GRA			AMIE			
Maryland	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing	Address (Street	and Numb	per or Rural Hou DDTVE	DEDI	IN MD 2	1911
	DEN =		MARVIN DAVIDSON / HUSBAND			ition (Name of	KEEF	DRIVE -	DLKL 3	20c. Location - C	ity or Town, State
ore	of He of He fiten r oth		20a. Method of Disposition 1	cemeter	y, crem	atory or other pla	Ce)	10/12/2			ALLSTOWN, MD
<u><u>Ĕ</u></u>	Pages ment of ent: If it ury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	REIH E	L Y 1	EMORIAL	es of Faci	10/12/2	EVINS		OS., INC.
Baltimore,	permit. Pages 1 and Department of Heall Importent: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee		Q	OOO PFIS	TFRST	OWN ROA	D - P	IKESVILL	E, MD 21208
Ш	20 E # 9		The disconstitutions that cause	ed the death. Do r	not ente	er the mode of dyi	ing, such a	s cardiac or res	piratory arre	est,	Approximate Interval Between
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	line.		ac N	1	_			Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	is a consequence		OF BO	eas)				2 years
	/Medical Examiner		Due to (or a	13 & CONSUQUONO	0.,.						
b		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s a consequence	of):						
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c								
Ć	icate be executed physician and s the burial-transit	Exa	resulting in death) Last Due to (or a	as a consequence	of):						
68760	te be lysicia ne bu	cal	d								
	certificate be executed rding physician and ise as the burial-transil	/Medical	IF FEMALE: 23c If was outcome	no of pregnancy						23d. Date	of delivery
Box		- 1 5-	23b. Was decedent pregnant	2 Fetal death at time of death		Ectopic pregnan Other (specify)	су			Mon	th Day Year
	e dea the al	Physicia	1 Yes 2 No 9 Unknown		0						
P.0	iaw requires that the death as been signed by the atter 2 should be detached for i			h but not resulting	in#he u	nderlying cause g	given in Pa	rt I.	23e. Did to	1	ibute to the cause of death?
Records,	signe be d be	Completed by	Delmonay	EMBOL	ur	¥			1 🗆 Y	es 200 No	3 Probably 4 Unknown
Ö	requ been shoul	ete							24a. Was a	an 24b. V	Vere autopsy findings available prior to completion of cause of
Rec	The lav	9							perfor	meg?	leath?
e	in: Ti ificate or, pa							ace of Death (C			DAUGHTER'
Vital	ting Physicien: The lav n. After this certificate has funeral director, page 2	8	examiner? 1 Yes So No Hospital: 1 Inp	atient 2 ER/C	utpatie	nt 3 DOA					er (Specify) RESIDENCI
of	g Phy er thi	-		Injury 28b. Day Year)	Time of Injury	V	york?		. Describe n	now injury occurr	80
jor	Attending r death. sctor: Afte by the fune	1	1 Matural 5 Pending investigation 2 Accident Could get be		4		Yes 2		Location (S	Street and Numb	er or Rural Route Number,
Division	er de	19:4	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place o building	Injury - At home, , etc. (Specify)	tam, s	treet, ractory, offic	26	20	City or Tov	vn, State)	
	Itel or real Dir	3	29a. Certifier Certifying Physician: To the b	act of my knowled	ae dea	th occurred at the	e time, date	and place, and	I due to the	cause(s) and ma	unner as stated.
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	and along Cortification.	29a. Certifier Check only one) 29a. Certifier Check only one) 1 Certifying Physician: To the base and manner on the base and manner on the base one)	is of examination a	and/or i	nvestigation, in m	y opinion,	death occurred	at the time,	date and place,	and due to the cause(s)
	To the within 2 To the complet		29b. Signature and title of certifier			29c. Lice	ense numb	oer		29d. Date signer	d (Month, Day, Year)
	7 × 5		1) . 1 1/11 1	7		40	72.00	7710		10/1	1/04
	V		30. Name and address of person who completed cause	of death (Item 23a	a) (Type	e, Print)					
	1		Danie Galder DO 6190	of death (Item 23a George 40 Gistrar's Signature	un	Blud E	Iden	buny 1	nd a	1184	
		Stat	e 31. Date filed (Month, Day, Year) 2004 32. Re	gistrar's Signature	4	lon	1/1				
- 1		etro	NO 11 1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	70	1	MUNIC	No.				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Estrada-Ojeda Regina 10 2004 5:30pm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Genesis Perring Parkway 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2/C)¥ Yrs. Director 080-26-7430 9-7-17 Puerto Rico Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itam 27 is marked other than "natursi", or items 23s or 28s-f show other traumatic event, the Medical Examinar results the notified at 1√ Yes 2 No Directo Md. NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1801 Wentworth Rd. 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: þ Hispanic 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2nd grade Seamstress Varies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Fint: If item 27 is marked of Rivera Julia Estrada Jose Rivera 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Granddaughter 29 Meteor Court, Baltimore, Md. Judy Rivera 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ortent: If i permit. Page Department of Importent: If any injury or Puerto Rico National 10-18-04 Bayoamon, Puerto Rico 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, & lady Wana 1101 E. North March F.H. East Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILLATERAL FFEUSION **Physician** TWO MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CONDWARY has autopsy certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:

Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl To the Funerei Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0061765 theliner UCTOBER 12 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

4 2004

Box 68760

32. Registrar's Signature

ERENEZEN QUAINOU MUD LOCIL RAVEN BLUD PUB #303 BALTIMONE MUD 21239

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Maryland 21215-0036	ould be 1 Mental I arked o	o Be	Stephen	Ellison			Mar	_	wet.t.		
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Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other then "natural", or Items 23s or 28s-f show treumatic event, the Medical Examinar mast be notified at	To Be Completed by Funeral Director	10e. Street and Number 7735 B & A BLVD., APT D 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Provinced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) NORMAN EASTON SR.	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, W 1	merican Indian, /hite, etc. WHITE ess/Industry							
Baltimore, Ma	permit. Pages 1 and 2 si Department of Heelth an Importent: If item 27 is r any injury or other treur once.	VANESSA EASTON - DAUGHTER 7869 LEYMAR DRIVE, GLEN BURNIE, MD 2 20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Duneral Service Uchnsels 22. Name and Address of Facility FINK FUNERAL HOM RELLY GREGORY FINK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE										
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	/Medie Examir		4a. Facility Name (If not institution, give HARBOR HOSPITA	street and number)			-tim	ORE,	MD MO		nty of Death	
	Funeral Director		5. Social Security Number 6. S 213-18-7657 Usual Residence of Decedent	ex M 2□F 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Y Months D		Jnder 24 Hr ours Mir		y, Year)		place (State or Foreign ntry) aryland
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8760,	/Medical Examiner physician and the purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. THORACOAD Cus to (or as a conseque) C. Due to (or as a conseque)	DOM I	NAL	ANEI	URYSI	М			TEN YEARS
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Division	in Line	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, stre	eet, factory, off	fice		28f. Location (S City or Tow	itreet and Num m, State)	nber or Rura	l Route Number,
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•	2		30. Name and address of person who	RNAL MEDICINE completed cause of death (Item 2 DOMO LU, MD	За) (Туре, І	Print)						2004
)	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 4 200	32. Registrar's Signatur	Θ	Som		ENSIN			PIC	1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Edith Gertrude 4:55 AM 2, 2004 October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard Millennium Health & Rehab Ellicott City | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 3, 1908 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Virginia Director 96 223-24-4566 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If itam 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Exertiner must be notified at 1 Yes 2 No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3000 North Ridge Road 21043 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2/QNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arah Francis Vianda Enna Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 66 Milburn Cir., Pasadena, MD 21122 Barbara Preissler (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Beahm's Chapel 10/8/04 Luray, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
The Bradley Funeral Home, Inc. Mmen 187 E. Main St., Luray, VA 22835 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carchio vascular Atherosclent **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Jas autopsy performed? certificate 1 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4K Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital viithin 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Back River Nocle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 ARIG MARMOUD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

4 2004

			1 - For State Registrar		of Marylar	•	artment of H		d Mental Hy	Reg. No.	104	32509
	Physici	an	Decedent's Name (First, Middle						2. Date of D	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution		V.	EVAN	4b. City, Town, or	r Location of D	OC+.	06	ounty of Death	6.00 H
	Examin	er	Manokin Manor N			Center		ess Ann		40.0	•	erset
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth		lace (State or Foreign try)
	Funeral Director		216-56-0463	1□M 2∰F	9	7 Yrs.	Months Days	Hours N	nin. <i>(Month, D</i> August	ay, Year) 2, 1907	7 Maryl	
	9		Usual Residence of Decedent							• • • • • • • • • • • • • • • • • • • •		
	aryler show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				1	0d. Inside City Limits 1 Yes 2 No
	Ba-f.	5		erset				sfield_				
	vith th	Directo	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Coun	•
	death with the Marylend rms 23a or 28a-f show r nust be nutitled at	rai	410 Myrtle Str		andast Francis I	10 10 1	Man Danadant of II	21817		- 14	USA . Race - Americ	
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed	ecedent Ever in U Forces? s 2 🕅 No	7.5.	f Yes, specify Cuba	in, Mexican, Pu	? (Specify Yes or Nuerto Rican, etc.)	0-	Black, White,	
S.	hours efter tural', or ite al Examine	by	3 ☑ Widowed 4 ☐ Divorced	If Yas	Give		I□Yes 2∏ No	Specify:		S	pecify: Wh	nite
รุ	72 hou		15. Deceden	t's Education	-A	16a. Dece	ient's Usual Occup	ation		16b. Kind	of Business/Inc	dustry
215-003b	.hh 7 .m. m. Mad	De le	(Specify only highe Elementary/Secondary (0-12)	-T	(1-4or 5+)	life.	kind of work done o OO NOT use retired	dunng most of d)	working			
7	flled within Hygiane. Ither than " ent, the Ma	Completed	8				Homemake:					1 Home
_	0 = 0 5	Be	17. Father's Name (First, Middle,	Last)					Name (First, Middle		ımame)	
<u>X</u>	ould Men Parke	2	Noah T. Evans			401 14 11			M. Jones			
Z Z	12 st h and 7 ts n treun	11	19a. Informant's Name/Relations				-		Rural Route Numb	-		•
o _	1 and Heelt em 2 ther		Nicholas T. Eva 20a. Method of Disposition	ins (Son)	20b.	Place of Dispo	sition (Name of	1	. Road — N		tion - City or To	ryland 2144 wn. State
ခွဲ	ages nt of nt of r or o		1 ⊠ Burial 2 ☐ Cremation		m State		natory or other place		30 000			
Baltimore,	permit. Peges 1 and 2 should b Department of Heelth and Ments Importent: If Item 27 is marked any Injury or other treumatic a <u>once</u> .		 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service 	. A	Sur						ıstıeld	, Maryland
g	Dapi Impo		Maysoth	SCO-PAG	Wille	11			Funeral H		MD 01	017
			23a, Part1. Enter the disease, or	radshaw- complications tha	t caused the dea				et - Cris diac or respiratory a			Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause or				Interval Between Onset and Death				
	/Medical		disease or condition resulting in death)	a	o (or as a conse	quence of):						
	Examiner		Convention to the line and disease	b	Dem	inna						
	v =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 1	o (or as a consec	quence of):						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	. /							
/6C	ate be executed hysician and the burlal-transit	al E	roduling in dodiny cast	Due	o (or as a consec	quence oi):						
Š	physi s the b	dicai		d								
×	death certificate e attending phys id for use es the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	outcome of pregn	ancy				236	d. Date of delive	irv
X Q	death atter	ciar	in the past 12 months? 1 □ Yes 2 ☑ No	4∐Pre	e birth 2 □ Feta gnant at time of o]Ectopic pregnancy] Other <i>(specify)</i>				Month	Day Year
o.	the tree	hysi	9 Unknown	9□ Unl	known							
,,	lew requires that as been signed b 2 should be deta	by P	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
Ĕ	w require been slg should b	edt							_ 1□	Yes 2□	No 3 ☐ Prob	ably 4 @Unknown
ecords,	ewre as bee	Completed							24a. Was	an :	24b. Were autop	psy findings available inpletion of cause of
ľ	The ate his	ĕ							perf	ormed?	death? 1 ☐ Yes	
Vital H	Physician: The lew this certificate has braidirector, pege 2 s	Be (25. Was case referred to medica examiner?				1		Death (Check only	one)		
<u> </u>	Physic this o	ဥ	1 ☐ Yes 2 ☑ No			ER/Outpatien		4 Nursin	g Home 5 ☐ Res			")
	ding P	inol.	27. Manger of Death 1 ☑ Natural 5 ☐ Pendir	'9	te of Injury onth, Day Year)	28b. Time of Injury	Worl	yat k? Yes 2 ∐No	28d. Describe	how intury o	occurred	
S	ten for the	icat	2 Accident investi 3 Suicide 6 Could	not be	co of Injury - At h	nome form etc	M 1 1	195 Z NO	28f Location	Street and I	Number or Rum	l Route Number,
DIVISION	after Direction by	Certification:	4 ☐ Homicide determ	ined bui	Iding, etc. (Speci	fy)	sei, factory, office		City or To	wn, State)	V2/1100/ G/ 110/G	7110010 74077007,
	spita nours neral		29a. Certifier 1 Certifyin	ng Physician: To 1	he best of my kn	owledge, death	occurred at the tim	ne, date and pla	ace, and due to the	cause(s) ar	nd manner as st	ated.
	ne Ho ne Fu	edicai	(Check only 2 Medical one)	Examiner: On the and ma	basis of examination	ation and/or in	estigation, in my o	pinion, death or	ccurred at the time,	date and pl	ace, and due to	the cause(s)
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ĕ	29b. Signature and title of certifie	,			29c. License	e number			signed (Month, I	Day, Year)
1			Nel	w			04	7094		146	104	
	2		30. Name and address of person			m 23a) (Type,	Print)		57., 59	chi	Des	A 21804
			21 Date fited (Month Day Year	NATERAN	Registrar's Sign	1415	50U# D	IV IS ION	57.	2137	7 M	5-10-7
	Sta Registi		31. Date filed Month, Day, Year,	ria L	Hegistrar's Sign	4	don sig					
1				The state of the s	*	N	apar Kal					

04-06533 Kim Foxwell RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	4	- For Unpend Item Registrar	23a&27°pe	me G8	Certi	ificate of L	as Death		Reg. No.	Commercial	32510
Physician /Medical	۱	1. Decedent's Name (First, Middle, La KIM FOXWELL	st)					2. Date of De	er Po, 2	20 ඊ 4°	3. Time of Death 0202A • M
Examiner		4a. Facility Name (If not institution, given Howard County Ge	neral Hos	pital		4b. City, Town, or Columbia			Howa		
Funeral Director		3,0 30 3,31	9x 7. A □M 2[文F	ge (In yrs. last b		If Under 1 Year Months Days	If Under 24 H Hours M		±1960		place (State or Foreign SHINGTON, DO
with the Maryland or 28a-f show be rolllled at	Ī	Usual Residence of Decedent 10a. State 10b. County MD • HOWARD		10c. City, Too							10d. Inside City Limits 1∏Yes 2 ☐ No
23a or 2		10e. Street and Number 5657 THUNDER F	IILL RD.			10f. Zip Code 21045			10g. Citizen d US.		ntry?
036 urs after death v urs after death v alt, or items 236 Exeminer must	2	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give 2 Year or Dates:	:? }No	If Y	as Decedent of His Yes, specify Cubar Tyes 2 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		ace - Americ lack, White, sify: BLA	etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene, when than natural, or items 23a or 28a-f show ant, the Macited Examiner must be notified at a Completed by Funeral Director	palaldillo	15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12)		(5+)	(Give kii life. DC	nt's Usual Occupa nd of work done d O NOT use retired) ERCARE PF	uring most of v	vorking	16b. Kind of	Business/In	
Maryland 212. d 2 should be filed within and Mental Hygiene. The marked other than traumatic event, the M.	0	17. Father's Name (First, Middle, Last CHARLES TANNER						lame (First, Middle HAH BRADI		ame)	
ore, No. 1 and of Health Item 27		19a. Informant's Name/Relationship (FRITZ FOXWELL (20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Constion 5 □ Other (Special	HUSBAND)	20b. Place cemet	5657 of Disposit ery, crema		HILL R	D. COLUME	BIA, MA	RYLANI	21045
Baltimo		21. Signature Funeral Service Licel	Sline C	20	650	Name and Address O ALLENT	of Facility S'	TRICKLANI . CAMP SI	FUNER	AL SEF	RVICE AND 20748
bhysician and physician and the burial-transit transit		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	bDue to (or a	s a consequence s a consequence s a consequence	e of):						Onset and Death
of Vital Records, P.O. Box 68 Physicien: The law requires that the death certificate has been signed by the attending priral director, page 2 should be detached for use as the completed by Physician/Med.	nysiciarymed	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ∰ Unknown		e of pregnancy 2		ctopic pregnancy Other (specify)				ate of delive	ery Day Year
	2	Part II. Other significant conditions of	contributing to death	but not resulting	in the und	erlying cause give	n in Part I.		obacco use co Yes 2 □ No		he cause of death? pably 4 tanknown
of Vital Records, Physicien: The law requires to this certificate has been signe ral director, page 2 should be to the Commileted by	Complete							24a. Was auto perfo 1 X Yes	psy ormed?	Were auto prior to co death? 1 XYes	psy findings available mpletion of cause of
ding h. After fune	2	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be		jury 28b. Jay Year)	Time of Injury		r: 4 □ Nursing at	g Home 5 Resi	dence 6 🗆 O	ırred	
Division To the Hospital or Attending within 24 hours effer death. To the Funeral Director After completely filled in by the fune Medical Certification		4 Homicide determined	building, e	njury - At home, to atc. (Specify) st of my knowledge	ge, death o	occurred at the tim	e, date and pla	City or To	wn, State) cause(s) and r	nanner as si	N Route Number,
To the Hospital within 24 hours to the Funeral completely filled	Medic	(Check only one) 2 Medical Example (Check	niner: On the basis and manner s	or examination a stated.	ind/or inve	29c. License	number	curred at the time,	29d. Date sign	ed (Month,	Day, Year)
	1	30. Name and address of person who	completed cause of RWB10,	death (Item 23a)) (Type, Pr	111 Pe	nn Str	eet, Balt	imore,	Mary]	Land 21201

			- I lease I	State of Maryland	d / Departmer	nt of Health and	Mental Hygi	ene	
		•	for State Registrar	,	•	te of Death		2004	32511
	Dhuaisia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		JANIE		ELL	न्ता"।	COTOBER	08 200	+ 0845 AM
	Examin	er	4e. Facility Name (If not institution, give s	of altro	-10/ 46. City	Town, or Location of Dea	tn	4c. County of Dea	ith
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		r 1 Year If Under 24 Hrs		9. Bi	rthplace (State or Foreign country)
	Director		212-28 - 6046	M 2∏F 71	Yrs. Months	Days Hours Min	Nov 1, 1		ryland
bu	3		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
Maryla	of s	ō	MD Harford		Forest H	i11			1 ☐ Yes 2√☐ No
the c	r 28a	Funeral Director	10e. Street and Number		10f. Z	p Code	10	g. Citizen of What C	country?
tiw di	23a o	ai D	1400 Boggs Road			21050		US	
or dea	tems Fr. mar.	nue	11. Wantai Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dece If Yes, spe	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
o affect	l, or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes	2 ▼ No Specify:		Specify:	white
U Z I Z I 3-0030	sture ical E	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Decedent's Usi	ual Occupation	orkina 1	6b. Kind of Busines:	s/industry
i i i	e u	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ork done during most of wo use retired)			
7 7	Hygiene. other than ant, the M		17. Father's Name (First, Middle, Last)	3	homemake		me (First, Middle, M		home
2	Mental Parked of	To Be	David Burt Jam	es		Elizab	eth Mae Bu	chanan	
ar yie	PES	۲	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailing Addres	ss (Street and Number or F	lural Route Number,	City or Town, State,	Zip Code)
Mi ,	aalth a n 27 is ar tra		Barry Elliott/so			gs Road Fores			
	If iter or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	l a	Place of Disposition (Na emetery, crematory or	other place)	Date 2	0c. Location - City o	r Town, State
	: 문문을 .		* 4 Donation 5 Other (Specify) 21. Signature of Euneral Service License		22 Names	and Address of Facility			
ם ם	Depa Impo any i		Jernie //	de, Director		Anatomy Boar ore, MD 212	d 655 W. 1	daltimore	Street
i		1	23a. P. rt1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death	the state of the s				Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	ACUTE	RENAL	FATLUE	E		Onset and Death ADAYS
	/Medical xaminer		resulting in death)	Due to (or as a consequ	uence of):				7-1136
	.xaiiiiici	<u></u>	Sequentially list conditions,	Due to (or as a consequ	uence of):	OLYSIS			TDAYS
pot	neo.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ANTOTALL!	NE HEN	DLYTTE A	NEMTA.	WARM	MONTHS
'n.	ician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):	. /		4	N. /
- 9	2 2 9	licai		HCVIE 1	MELOGE	NOUS L	EUKEL	LIA	MONTHS
X OX	e attending phi d for use as th	by Physician/Med	IF FEMALE: 2	3c. If yes, outcome of pregna	ancv			23d. Date of de	alivary
X O D	atten	cian	23b. Was decedent pregnant in the past 12 ponths?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3 ☐ Ectopic			Month	Day Year
j j	by the	hysi	9 Unknown	9□ Unknown					
, S	ine law requires that the ite has been signed by th bage 2 should be detache	by P	Part II. Other significant conditions cor	tributing to death but not resi	ulting in the underlying	cause given in Part I.	_	4.4	to the cause of death? Probably 4 □Unknown
ecord	bluor bluor	ted					1 Tes		
င္	8 9 01	Completed					24a. Was an autopsy perform	prior to	autopsy findings available ocompletion of cause of
	(U	e Co	25. Was case referred to medical			26 Place of D	perform 1 ☐ Yes 2 eath (Check only one	No 1□Ye	s 2 No
1	rnysician: this certific ral director,	0 8	avaminer?	lospital: Inpatient 2	ER/Outpatient 3 0	Other	Home 5 ☐ Resider		ecify)
		J.i.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
SIO	or Attending after death. Director: After in by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		М	1 ☐ Yes 2 ☐ No	COS Lacation (Can		Dural Bouta Alumbar
Division	or An after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	City or Town,		Rural Route Number,
_	To the Hospital or Attanding Fr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier Certifying Physical Certification	sicien. To the best of my kno	owledge, death occurre	d at the time, date and pla	ce, and due to the ca	use(s) and manner:	as stated.
	n 24 f n 24 f he Fu pletely	edical	(Check only 2 Medical Exami	ner On the basis of examina and manner stated.	ation and/or investigation	on, in my opinion, death oc			
1	within 2 To the	Σ	29b. Signature and ottle of certifier		2	9c. License number		d. Date signed (Mor	
1			MIC	MD	- 220) (T 2	25-000	Oc.	TUBER C	8,2004
			30. Name and address of person who co	EP 401	1 23a) (Type, Print)	DWAY	BALTI	MORE!	8,2004 4D 21231
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature			1	
	Regist	rar	UC 1 1 4 2004	Dene	7 Annah	51			

		1 - For State Registrar	State of Maryland / Dep Ce	partment of Health and ertificate of Death	Mental Hygier	ne	32512
Physici		1. Decedent's Name (First, Middle, Las Arthur Clyde El			2. Date of Death Month September	Day Year 13 2004	3. Time of Death
/Medio Examir		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Deat		4c. County of Death	1
		1 Manchester F		Silver Spring Will If Under 1 Year If Under 24 Hrs		Montgome	
Funeral Director		5. Social Security Number 170–34–8930 6. Security Number 170–34–8930	7. Age (In yrs. last birthda) X M 2□F 60 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day, Yea	9. Birthp Coun 944 Penns	lace (State or Fore try) Sylvania
Within 72 nous arier beant with the maryand 80s. Then "natural", or Items 23a or 28e-f show The Medical Exacting Invest be notified at	tor	10a. State 10b. County MD Montgor	10c. City, Town or aery Sil	Location ver Spring		1	0d. Inside City Limi
a or 28e Lee roll	Funeral Director	10e. Street and Number 1 Manchester Plac	e #204	10f. Zip Code 20904	10g.	Citizen of What Coun	itry?
ns 23	era	11. Marital Status		8. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	USA 14 Race - Americ	an Indian,
al', or Iten		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Amed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	to Rican, etc.)	Black, White,	_{etc.} hite
if of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28e-f show or other treumetic event, the Medical Evanirys indist be collined.	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) unk u	ucation 16a. Dec (Gir (Gir (Internation)) College (1-4or 5+) nk	pedent's Usual Occupation we kind of work done during most of wo . DO NOT use retired)	unk 16b.	. Kind of Business/Ind	dustry un
nd Mental Hygiene. marked other then imetic event, the M	To Be C	17. Father's Name (First, Middle, Last) Orville Ellio	tt		me (First, Middle, Maid Sibert	den Sumame)	
and lis ma		19a. Informant's Name/Relationship (7		iling Address (Street and Number or Re	ural Route Number, Cit	y or Town, State, Zip	Code)
Health		OCME			altimore, M		
nent of He ent: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 ☑ Other (Specify	Removal from State cemetery, ci	position (Name of rematory or other place)	Date 20c.	. Location - City or To	wn, State
Department of Importent: If i any injury or once.		21. Signature Euneral Stryice Licent Ron d S		22. Name and Address of Facility State Anatomy Boar Baltimore, MD 212	d 655 W. B.	altimore S	treet
/Medical /Medical saminer	Examiner	shock or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Cardiovascular Dis	sease		Interval Between Onset and Death
y the attending phy. Iched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		B□Ectopic pregnancy □ Other (<i>specify</i>)		23d. Date of delive	ry Day Year
50 00	by	Part II. Other significant conditions o	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death? ably 4 🕍 nkno
	Completed				24a. Was an autopsy performed 1 Yes 2	prior to cor eath?	psy findings availa inpletion of cause of
this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	04	ath (Check only one)		
After this funeral di	tlon; To	1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	Home 5 Residence 28d. Describe how in		Scene
within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined		street, factory, office	28f. Location (Street City or Town, St.	and Number or Rura ate)	l Route Number,
n 24 hour he Funera stetely filla	edical (29a. Certifier 1 Certifying Ph (Check only one) 1 Medicel Example 1 Medicel Example 1 Medicel Example 1 Certifying Ph	ysicien: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
within 2 To the complet	Me	29b. Signature and title of certifier	elan md	29c. License number O.C.M.E.		Date signed (Month, i	
		30. Name and address of person who	completed cause of death (Item 23a) (Typ				
St. Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	land			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician october 11, 2004 3:45р м LAURA EDWARDS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death BALTIMORE TOWSON MANOR CARE NURSING CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1□M 2 F Hours TRGINIA 87 Yrs. 216-10-2219 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ₹ Yes 2 No Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2528 GARRETT AVE. 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK ģ 3 XWidowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CATERING FOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be f Mental I PEARL PULLUM WILLIAM WILSON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Importent: If item 27 is
any injury or other tren. RALPH JOHNSON(SON) 216 CHESTER ST. BALTIMORE, MARYLAND 21231 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 10-15-2004 BALTIMORE, MARYLAND ` 4 ☐ Donation 5 Other (Specity) HIBNES Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. lineral Service Living IONATHAN 21. Signatura of 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (*r as a consequence of): death certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Noknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 🗌 Yes 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Vursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No investigation Director; 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a the Funerel C 1 Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) othe Hu within 2 To th 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0-0012849 Julaa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SLER DV. TOWSON MD 21204 1600 31. Date filed (Month) 32. Aegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #20a-c PER FH C836 entification of Per FH C836 entificat 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Yeer Physician **GEORGE** DOUGLAS **EDWARDS** October 9 2004 11:10 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE N/A JOSEPH RICHIE HOSPICE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months (XX)M 2□ F Yrs. 48 Director Sept 3 1956 214-64-7100 NORTH CAROLINA Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location Show 10b. County r than "natural", or Items 23a or 28a-f shov If a Medical Examiner must be notified at XXYes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2217 W BALTIMORE STREET 21223 Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? ₩XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Yes, Give ear or Dates: 1 ☐ Yes 2\(\times \text{No}\) Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER WAREHOUSE 12th grade and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE POPE ု ELOUISE EDWARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 2217 W. Baltimore St., Baltimore, Md Edna Edwards/Aunt 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition MI ZION CEMETERY 10/19/04 1 X Kurial 2 □ Cremation 3 □ Removal from State LANDSDOWNE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. W NORTH AVENUE 206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. 1 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of deat. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3/ Probably Completed Were autopsy findings available prior to completion of cause of death?

1 \(\) \(y \) y \(\) y \(\) 2 \(\) No 24a. Was an 1 ☐ Yes 2 7 N Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA 2 5 Residence 6 Dother (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury uneral Death 28b. Time of occurred 27 Mannel Certification: 5 Pending investigation Injury 1 Latural 1 ☐ Yes 2 ☐ No

of Vital Records, seorde

death. Director: within 24 hours To the Funeral

State Registrar

filled in by

Medical

29b. Signature and title of certifier

6 Could not be determined

determ

2 Accident

3 🗀 Suicide

29a. Certifier

4 T Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Type, Print

4 2004

29c.

			1 - For State Registrar		State of	Maryland		artmen <i>rtificate</i>				1ental Hy	giene Reg. N	200	11.	20515
			Decedent's Name (First, Mide	fle, Last)								2. Date of De	ath		12.	3. Time of Death
	Physici		Phyllis	Caro	1	Freeman						OCTUBEY	Da		Year OOU	9:35 PM
	/Medic		4a. Facility Name (If not institution	on, give s	reet and num	nber)		4b. City,	Town, or	Location of	of Death		40		of Death	
			Johns Hopkins P	UNVI	W Meo	Arcul (21	nter	12	ben Iti	mor	9					
	Funeral Director		5. Social Security Number 218-74-1425	6. Sex	м 27 г	7. Age (In yrs. Ia 46	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Jan 20	th $_{y, Y \theta ar}$	58	9. Birthp Cour Mar	place (State or Foreign ntry) y Land
	D		Usual Residence of Decedent 10a, State 10b, Count			10c City	Town or Lo	ocation							I a	0d. Inside City Limits
	shov	7	- 1	, imore	2											1 ☐ Yes 2- I No
	R8a-f	Director	MD Balt 10e. Street and Number	TINOT		Du	ndalk	10f. Zip	Code				10a Ci	itizen of \	What Cour	
	with t	5	1201 Old North	Poi	nt Roa	đ			1222				-	JSA	Wilat Coul	tuy :
	death with the Marylend ms 23a or 28a-f show rmust be notified at	Funeral	11. Marital Status		2. Was Dece	dent Ever in U.S	13.	1			igin? (Sp	ecify Yes or No			e - Americ	an Indian,
^	fler d	Fun	1 Never Married 2 Ma	rried	Armed For 1 ☐ Yes	2 🛣 No						ecify Yes or No Rican, etc.)		Bla	ck, White,	etc.
2	hours efter tural', or ite	b	3 Widowed 4 Divorce		If Yes, Give Year or Da	e ites:		1 ☐ Yes	2 ANO	Specify:				Specif	y: W	hite
9500-61212	be filed within 72 hours effer death with the Marylen ital Hyglene. d other then "natural", or Items 23a or 28a-f show event. The Medical Examinar must be notified at	Completed	15. Decede (Specify only high				16a. Dece	dent's Usua	al Occupa	ation during mos	t of work	ina	16b. F	Kind of B	usiness/In	dustry
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L,		١.	Immediate Cause (Final	st only on	e cause on ea	ach line.			olvo							Onset and Death
-	Priysician /Medical	1	disease or condition resulting in death)	a		or as a conseque		341	10110	**16					-	3 days
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	10.	ē	Sequentially list conditions, if any, leading to immediate	ь	Due to (or as a consequ		001	17 [9							
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 .	Ac	ute reno	al fea	ilure								3 days
o	cate be executed physicien and the burial-transit		resulting in death) Last		Due to (or as a consequ	ence of):									
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Ó	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	a)	IF FEMALE:													
Rox	leath certifii attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23	1 Live bi	come of pregnar irth 2 🗌 Fetal	death 3	⊒Ectopic pr							te of delive onth	Day Year
	e dea the at	sici	1 Yes 2 No		4□Pregn: 9□Unkno	ant at time of de own	ath 5	Other (sp	ecify)							,
0	res that the de signed by the a be detached f	Ph)	Part II. Other significant condi	tions con	tributina to de	ath but not resul	Iting in the u	ınderivina c	ause divi	en in Part I		23e. Did	tobacco	use conf	inbute to th	ne cause of death?
Records,	signe signe	by	Circhosis To	1108 7	-	hetes,				AND		10	Yes 2	DKNo	3 ☐ Prob	ably 4 Unknown
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	vicien: The la certificate has rector, page 2											1 🗆 Yes	2 N		1 🗆 Yes	20 No
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on	ding h. Afte fune	tlon	1 XNatural 5 ☐ Pend	ling tigation	(Mont	h, Day Year)	Injury	м		k? Yes 2□	No					
Division of	Atten deat ctor: y the	fica	3 Suicide 6 Coul	_	28e. Place	of Injury - At hor	ne, farm, st	reet, factory	, office		T				per or Rura	I Route Number,
2	after after Dire	Certification;	4 Homicide	7711100	buildir	ng, etc." (Specify,)					City or To	wn, Stat	(e)		
	To the Hospitel or Attending Physicien: Juhin 24 hours after death. To the Funeral Director: After this cartification is the funeral director, to the funeral director.	edical C	29a. Certifier 1 Certify (Check only 2 Medic	ring Phys al Examir	lcien: To the er: On the ba	best of my knov	vledge, deal on and/or ir	th occurred rvestigation	at the tim , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date an	s) and mand place,	anner as si and due to	tated. the cause(s)
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	0		30. Name and address of person	n uto so	moleted sauce	a of death (Item	23a) /Tupo	Print)	ingo i	A 2 1	,	- 1	00	O VIC V	. [050
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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Mattie M. Faust 11:15 A October 9, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3204 Scottish Avenue Suitland Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
5 (Month Day (9ar) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours West Virginia 1 □ M 2 🖵 F 578-24-2957 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or Items 23s or 28e-1 show ury or other treumatic event, Ite Medical Examinations the notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 X No Suitland Maryland Prince George's Directo 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 20746 USA 3204 Scottish Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 34 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Federal Government statistician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mattie D. Nutty Asbury C. McNeer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10439 Tullymore Dr. Adelphi, MD. 20783 Ralph M. Faust/Son 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Cedar Hill Cemetery 10/12/04 Suitland, MD. permit. Page Department o Importent: If any injury or once. * 4 □ Donation 15 □ Other (Specify) 21. Signatura i Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, MD 20745 234 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner S- quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Exam Due to r s a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate 21 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No 은 this Director: After this in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eaton, MD 7350 Van Dusen Rd. #130 Laurel, MD. 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 4 2004 Registrar

			1 - For State Registrar	State of Ma	ryland / De <i>C</i>	partment e <i>rtificate</i>	of Healt of Dea	th and M ath		iene eg. No.	004	32517
	Physici		1. Decedent's Name (First, Middle, Last Charito) C.	Fe	rnande	z		2. Date of Dea Month Ctober		2004	3. Time of Death 11:46 A M
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)			Town, or Locat		CCODCI	-	unty of Death	
	LAAIIII	161	9110 Cooper Drive			1	Washi				nce Geo	
	Funeral		Social Security Number 6. Se		(In yrs. last birthda	y) If Under	1 Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth	1	9. Birth	place (State or Foreign
	Director			[™] X XF 56	Yrs.	Wioritis	Days		4/29/19	48	Phil:	ippines
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
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	th with	aiD	9110 Cooper Drive				207	44		U	SA	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then *netural', or items 23e or 28e-f show any injury or other treumatic event, it is Madical Exacting number or political at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	ver in U.S. 1	If Yes, speci			cify Yes or No- Rican, etc.)		Race - Ameri Black, White, Decify: AS18	
215-0036	hin 72 ho an "netura Madical	Completed	15. Decedent's Edit (Specify only highest grad	cation le completed) College (1-4or 5-	(Gi	cedent's Usual ve kind of work . DO NOT use	k done durina	most of workir	ng	16b. Kind	of Business/In	dustry
2121	ad wit giene er the	Com	Listing (5 12)	+	Nurs	e				Heal:	th Care	9
Maryland	ould be filk Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Antonino L. Cort	es			Mai	ura Al	(First, Middle, I abanza			
, Mar	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship (T) Armando S. Fernanc						Route Number Washing			
Baltimore,	Pages 1 nent of Hu int: If iten		20a. Method of Disposition 1. Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,		20b. Place of Dis cemetery, of St. Mary	ematory or oth	her place)				ion - City or To on , Mary	
Balti	permit. Departnimporte any inju		21. Signature Funeral Sey Lic	las	6	eorgend 160 ux	paddregs of Fa	as Fune	ral Hom Oxon Hi	e, P.	A. ID 2074	.5
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line	the death. Do not e	nter the mode	of dying, such					Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a	10/eato	Care	_		¥ 4 W			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):				-	_		
,0928	sician and burial-transit	al Exa	that initiated events resulting in death) Last	Due to (or as a	consequence of):							
687	ficate physics the t	edical		d								
O. Box	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	□Ectopic pre				23d	. Date of delive Month	ery Day Year
Records, P.	uires that I signed by d be detai	by	Part II. Other significant conditions co	ntributing to death but	t not resulting in the	underlying ca	use given in P	art I.		oacco use		he cause of death?
Sor	> 11 0	ete							24a. Was a			
al Re	lcien: The law certificate has b rector, page 2 st	Completed							autops perform 1 Yes 2	y ned?	prior to co death? 1 Yes	psy findings available mpletion of cause of
Vital		Be C	25. Was case referred to medical examiner?	fospital:	• • • • • • • • • • • • • • • • • • •		Othor		(Check only on			
of	Phys rrthis aral di	. To	27. Manner of Death	28a. Date of Injury	t 2 ER/Outpat		c. Injury at Work?		e XX Reside 8d. Describe ho			(y)
ion	Attending I ir death. ector: After by the funer	ation	1 X Autural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injun	М	Work? 1 ☐ Yes 2					
Division	of the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, (Specify)	street, factory,	office	2	8f. Location (Sti City or Town	reet and N , State)	umber or Rura	il Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical C	29a. Certifier (Check only one) XX Certifying Phy 2 Medical Examination	sician: To the best of ner: On the basis of a and manner state	examination and/or	ath occurred a investigation, i	t the time, date in my opinion,	e and place, as death occurre	nd due to the ca d at the time, da	use(s) and ate and pla	d manner as si ce, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	4		29c.	License numb				gned (Month,	
•			1011	/ /			MD	33109		1	0/11/0	04
	10		30. Name and address of person who c	ompleted cause of de			V6, M	0		ESERVE		re
1	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar	's Signature	Spork	NG M					

State of Maryland / Department of Health and Mental Hygiene

				Otato of mic	C	Pertificate of	Death	Reg.	No 2004	32518				
			1. Decedent's Name (First, Middle, Le				2.	Date of Death	Dey Year	3. Time of Death				
	Physici /Medic			ale Funk				ctober	5 2000	4 7.10811				
	Examin	er	4a. Fecility Name (If not institution, given 830 W. 40th Stree		55		4b. City, Town, or Locat Baltimore		4c. County of De	N/A				
	Funeral Director		5. Social Security Number 6. S 213–10–3629	Sex 7. Age	e (In yrs. last birtho 99 Yr	Months Devs	Hours Min.	Date of Birth (Month, Day, Ye Oct 2, 1	ear) (irthplace (Stete or Foreign Country) aryland				
	pu 🛦		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	r Location				10d. Inside City Limits				
	r 28a-f show	ctor		I/A		ltimore				XX Yes 2 □ No				
	th with the 23a or 28 ust be no	Funeral Director	10e. Street end Number 830 W. 40th Street	et Apt. 75	55	10f. Zip Code	21211	10g.	. Citizen of What (USA				
020	72 hours after dea natural', or items lical Examiner in	by	11. Marital Status 11. Marital Status 12. Married 2. Married 3. Widowed 4. Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes ②IXN If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes XX No	Hispanic Origin? (Specifican, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White				
5-0		eted	15. Decedent's E (Specify only highest gre		16a. D	ecedent's Usual Occu Give kind of work done	petion during most of working ed)	168	b. Kind of Busines	s/Industry				
Maryland 21215-0020	withir iene. then the M	Completed	Elementary/Secondary (0-12) Unknown	College (1-4or 5	+)	te. <i>DO NOT</i> use retire Unkno			Unkno	own				
P	othe othe	BeC	17. Father's Name (First, Middle, Lest				18. Mother's Name (/							
yla	should be ind Mental is marked of	2	Harry Hughes Fund				Eliza Cha	-		7:- 0-4-)				
Mar	d2sh thand thand 7 is m traum		19a. Informant's Name/Relationship (Susan B. Hughes	(P. R.)	Mer	cantile Sa	tand Number or Aural F afe Deposit 7 Baltimo	No. Mossi	rty or rown, State	, 2ip Code)				
ā,	f Heali f Heali tem 2		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other ple	oce) Dartino	Date 200	c. Location - City of	or Town, State				
imo	Page nent o ant: if I		1 ☐ Burial XXII Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Balitmo	Litmore-Washington Crem- 10/13 Laurel, Maryland 22. Name and Address of Facility Burgace-Hopes-Soitz Funeral Home Inc.								
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Lice	Dealer		3631 Fa]	lls Road B	altimore	e, Maryla	inc. and 21211				
			23a. Part1 Enter the disease, or co shock, or heart failure. List on	plications that caused one ceuse on each lir	the death. Do no	t enter the mode of dy	ing, such es cardiac or r	espiratory errest	1	Approximate Intervel Between Onset and Death				
7	Physician /Medical		Immediate Cause (Final							6.4				
	Examiner		disease or condition resulting in death)	a	Due to (or es e co	preguence of:	carcina	mor		one year				
		ner	-5342	0	Due to (or es e co	nacquentes org.								
90,	The lew requires that the death certificate be executed at has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C	Due to (or as a co	nsequence of):								
x 68760,	n certificete anding physi use as the	ν/Medicai	that initiated events resulting in death) Last	d	Due to (or as a co	nsequence of):								
. Bo	death ce attendii d for use	iclar	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying cause di	iven in Part I.	23b. Did toba	icco use contribu	ite to the causa of death?				
P.0	et the de I by the a steched i	by Physician/	arteringelor	_	_	scular				Probably 4 Unknown				
ords,	v requires thet been signed t should be det	eted by	Compensate	el conq		Reart fo	nilevre	24a. Wes en a		b. Were autopsy findings aveilable prior to completion of cause				
Rec	The lew ate has b page 2 s	Completed						1 ☐ Yes	2 DNo	of deeth? 1 □ Yes 2 □ No				
ital	iclan: Th certificate rector, pa	BeC	25. Wes case referred to medical				26. Place of Death (
) t	hysiclan: this certificate al director,	P L	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		etient 3LI DOA	her: 4 Nursing Home			pecify)				
Z C	Jing Ph h. After th funeral	lon:	27. Menner of Deeth 1 □ Natural 5 □ Pending investigation	28e. Date of Inju (Month, Day	ry y <i>Year</i>) 28b. Tir Inji	ury Wo	ıryet 28i ork?]Yes 2 □No	d. Describe how	injury occurred					
Division of Vital Records,	or Attence efter death Director:	Certification:	2 Accident 3 Suicide 4 Homicide	oe Ope Diese of Init	ury - At home, farn c. (Specify)	n, street, factory, office		f. Location (Stree City or Town, S		Rural Route Number,				
_	Hospital 24 hours Funeral etely filled	Medical C				ime, date end place, and opinion, deeth occurred								
	To the within 2 To the сопры	Me	29b. Signature and title of certifier			29c. License number 29d. Date signed (Month, Dey, Yeer)								
			M. Istalle	The gre	Goz Mi	713	657	00	Yader 6	,2004				
	10		30. Name end eddress of person who	completed ceuse of d	leeth (Item 23e) (T	ype, Print)	STREET, B	ALTIVE	RE MO	21211				
	Sta	ite	7. IS IABELLE T 31. Date filed (Month, Day, Yeer)	7	ar's Signature	1	/			-				
	Regist		OCT 1 4 2004	hemme	19	Ann W. N								

4a. Facility Name (If not institution, give OAK CREST 5. Social Security Number 212-10-9055 Usual Residence of Decedent 10a. State 10b. County MD. BALTIN 10e. Street and Number 8820 WALTHER BOUL 11. Marital Status 1 Never Married 2 Married X Widowed 4 Divorced (Specify only highest grasselementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) HOWARD 19a. Informant's Name/Relationship (DAVID H. FILBER) 20a. Method of Disposition X Burial 2 Cremation 3 1 4 Donation 5 Other (Specification 1) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	WARD C. e street and number) VILLAGE EXAM 2 F 7. Age (In Age	4106 r in U.S. 13 16a. Dec (GA life) T 19b. Ma 1319 20b. Place of Dis cometary, cl	PAR If Under 1 Year Months Days ocation PA 10f. Zip Code 21 Was Decedent of If Yes, specify Cub I Yes, specify Cub adent's Usual Occupe kind of work done DO NOT use retire PRESIDE BURLEIGH POSSITION (Name of symatory or other plane)	and Number or Run ROAD, TIM TERY 10-15 Tens of Facility	ecify Yes or No-Rican, etc.) ing e (First, Middle, MCGO al Route Numbe ION I UM, M	11 - 4c. Coun 1917 10g. Citizen of 15b. Kind of ENGINE Maiden Suma	f What Country White Same Americal Cack, White, wifty: White Business/Incomment ERING Came) EMCGOMMA To Same Business/Incomment Cack, White, white, white, white, white, white Business/Incomment Cack, White, white Business/Incomment Cack, White, white Business/Incomment Cack, White, white Business/Incomment Cack, White Business/Incomment	olace (State or Formatty) ARYLAND Od. Inside City Lin 1 Yes 2 A. can Indian, etc. HITE dustry FIRM OWAN O Code) 093 own, State		
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shock, or heart failure. List only	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
disease or condition resulting in death)	a. Parking Due to (or as a co	oni D	Heure	- endutap				Interval Betwee Onset and Deat		
Sequentially list conditions, if any, leading to immediate cause. Enter the Cause (Disease or injury	b. Due to (or as a co	onsequence of):								
that initiated events c. resulting in death) Last Due to (or as a consequence of):										
	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	☐Ectopic pregnand ☐ Other (specify) _	су			Date of delive Month	ery Day Year		
Part II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cause g	iven in Part I.		./		he cause of deat bably 4 ∐Unki		
					autor perfo	rmed?	death?	opsy findings avai		
25. Was case referred to medical					th (Check only o					
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Tiratural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not a	be 28e. Place of Injury	M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office			28f. Location (Street and Number or Rura)			al Route Number		
4 Homicide	building, etc. (100000000	ath occurred at the	time, date and place			manner as s	stated.		
(Check only 2 Medical Exa	miner: On the basis of ex	amination and/or	investigation, in my	opinion, death occu	rred at the time,	date and plac	e, and due to	o the cause(s)		
29b. Signature and title of certifier	7		0							
30. Name and address of person who			e, Print)		00.15		voi ie	2009		
	9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 2 Accident 3 Suicide 6 Could not determined 29a. Certifier (Check only one) 29b. Signature and title of Certifier 30. Name and ad for s of person with	9 Unknown Part II. Other significant conditions contributing to death but not be a conditions and conditions contributing to death but not be a conditions and conditions are a conditions. 25. Was case referred to medical examiner: 1	Part II. Other significant conditions contributing to death but not resulting in the 25. Was case referred to medical examiner? 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g 25. Was case referred to medical examiner? 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did to 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of light of l	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the surprish to the surprish to condeath? 24a. Was an autopsy performed? performed? 1 yes 2 No 1 yes 2 No 1 yes 2 No 2 N		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 07 2004 11:55 ам **Physician** GENTRY AUDREY Т /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Arundel Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. Mariner Health of North Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F 2,1924 N. Carolina Director 238-30-9315 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryian ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other fraumatic event, Ita Medical Examinas mast be notified at Maryland Anne Arundel 1 Yes 2 No Pasadena Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 729 Bridge Drive U.S.A. 21122 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status t ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Acme Market 0 Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leona Day Paul Robbins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21122 7.29 Lynda Sellers (Daughter) Bridge Drive Pasadena lena Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10-11-04 Glen Burnie Md. permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Haven Mem Park 21. Signature of Fundral Service Licensee 22. Name and Address of Facility McCully-Polyniak F.H. P.A. 237 East Patapsco Avenue, enter the mode of dying, such as cardiac or respiratory arrest, 21225 nt1. Enter the disease, or complications that caused the death. Do not enter hock, or heart failure. List only one cause on each line. Baltimore Md. Interval Between Onset and Death mediate Cause (Final etas **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tranresulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed 1 Yes 2 No <u>a</u> Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Jurising Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title & certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATIOR SRIDHAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			1 - For State Registrar	Certificate of Death	Reg. No.2004 32521
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)	317.	2. Date of Death Month, Day Year 3. Time of Death
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lpcation of Death	4c. County of Deeth
			5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday) If Under 1 Year If Under 24 Hrs.	
	Funeral Director		212-07-0090 1 DM 21XF	88 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Parch 09 1916 9. Birthplace (State or Foreign Country) Maryland
Pos	A T		Usual Residence of Decedent 10a. State 10b. County 10c.	c. City, Town or Location	10d. Inside City Limits
Man	B-f sh	tor	Maryland n/a	Baltimore	YXYes 2 □ No
ith the	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
died	ns 23e	Funeral	9 W. Clement Street 11. Marital Status 12. Was Decedent Ever	21230 in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	United States ify Yes or No- 14. Race - American Indian,
2	s allen deall will the intelligent, or items 23a or 28a-1 show	Fun /	1 Never Married 2 Married 1 Yes 2 M No	If Yes, specify Cuban, Mexican, Puerto R	ican, etc.) Black, White, etc. Specify: White
3	natural, or	ed by	3 ∰ Widowed 4 □ Divorced Year or Dates:	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
2 5	tal Hygiene. Id other than "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	g
7 T	ygiene ver tha t, the	Сош	12 years n/a	Housewife	Home Owner
at yidii da kiibi a 1 K 1 S baus afar daah wih iba Mandad	c svsn	o Be	17. Father's Name (First, Middle, Last) Charles J. Beck	Mary	(First, Middle, Maiden Sumame) Corcoran
lai y	z should be fred within and Mental Hygiene. Is marked other than sumatic svent, the Mental Hygiene.	To	19a. Informant's Name/Relationship (Type, Print) Bonnie A. Travieso Personal R	19b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)
ב י'ב ב ע'ב	Health em 27			Ob. Place of Disposition (Name of Da	
Dalling	reges nent of I ant: If its			New Cathedral Cemetery 10/1	8/2004 Baltimore, Md.
	permit reges i and a should be permit reges i and a should be beatment of Health and Menta Important: If item 27 is marked any injury or other traumatic stones.		21. Signature of Funeral Service Licensee	MCCully-Polyniak 130 E. Fort Ave.	Funeral Home P.A. Baltimore, Md. 21230
9			23a. Part 1. Enter the disease, or complications that caused the shock, or hear failule. List only one cause on each line.	death. Do not enter the mode of dying, such as cardiac or	respiratory arrest, Approximate Interval Between
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	c Obstructive pulm	lonary Disease Years
	Examiner		Due to (or as a cor	onsequence of):	Vearc
7	D #	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Y
	al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a cor	vnsequence of):	
,007	ysicier he buri	cal	d		
00 X	ding ph	/Med	IF FEMALE: 23c. If yes, outcome of pri	regnancy	201 Date of delivery
DOX	attence d for us	Physiclan/Medl	in the past 12 months? 1 Vec 2 Pelo	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
)	at me of the stacher	Phys	9 ☐ Unknown		23e. Did tobacco use contribute to the cause of death?
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cords,	s been s been s shoul	olete			24a. Was an 24b. Were autopsy findings available
ב ב	ate ha	Completed			autopsy performed? death? 1 ☐ Yes 2 ☐ No
VIIai	certific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	
5 8	g Pnys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c, Injury at 28	e 5 Residence 6 Other (Specify) 8d. Describe how injury occurred
101	ending sath. or: Afte	ation	2 Accident investigation	ner) Injury Work? M 1 Yes 2 No	
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)		8f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ly knowledge, death occurred at the time, date and place, all amination and/or investigation, in my opinion, death occurre	
	the H hin 24 the Fi	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	N W S		Why w	20 D5-539	1 October 11, 2004
*	\		30, Name and address of person who completed cause of death		10-10-11
7	7	1	31. Date filed (Morith, Day, Year) 32. Registrar's S	on Avenue. Salti	more Maryland 2122/
	Sta Regist		OCT 1 4 2004 Dene	wa & Sparks	

			For Stete	State of Ma	aryland / Depa <i>Cel</i>	artment of He		, ,	0001	00700
			Registrar 1. Decedent's Name (First, Middle, Last,					2. Date of Deat		3. Time of Death
и	Physici		Mark Gonz	zalez				OCTOBER	9, 2004°	6:45a м
	/Medic Examin		4a. Facility Name (If not institution, give	4b. City, Town, or I	ocation of Death		4c. County of De			
	LXamin		81 VILLAGE MILL CO			OWINGS M	ILLS		BALTIMOR	E
	Funeral Director		5. Social Security Number 6. Security Number 128	7. Age	(In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	9. B 21, 1982	irthplace (State or Foreign Country) NY
			Usual Residence of Decedent							
	Marylan of show lited at	tor	NY 10b. County Bro	nx	10c. City, Town or Lo		York			10d. Inside City Limits 1
	with the	I Direc	10e. Street and Number 4200 Hutchinson	River Pkwy	Y /	10f. Zip Code 104	1 75	1	0g. Citizen of What 0	Country?
9	72 hours after death with the Maryland Insture!, or Items 23e or 28s-f show dissil Examination I set the cadified at	by Funeral Director	11. Marital Status ★★Never Married 2 Married	12. Was Decedent B Armed Forces? 1 XXes 2 N If Yes, Give	unk.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto Unk •	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc. Hispanic
003	urel',	d by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occupat			16b. Kind of Busines	
21215-0036	within 72 ene. than "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	kind of work done du DO NOT use retired)			16b. Kind of Busines	s/industry
	filed withii Hygiene. other than ent, the M	Con	1 2	0		Coast C		(E)		oast Guard
land	should be nd Mental marked maric ev	To Be	17. Father's Name (First, Middle, Last) Ralph Gonzalez					sabel Ot:	Maiden Sumame) ero	
Maryland		-	19a. Informant's Name/Relationship (T) Isabel Otero / Mo	rpe, Print) other		ng Address <i>(Str</i> eet ar Hutchinso			r, City or Town, State,	, Zip Code) L0475
Baltimore,	of Hea		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀	Removal from State		natory or other place	1 1/1/2	12/04	20c. Location - City of	or Town, State
Ë	it. Pag rtment rtent: njury o		`4 ☐ Donation 5 ☐ Other (Specify)	18 -1 D	Woodlawn	Crematory	10/.	13/04	Bro	onx NY
Bal	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other trat once.	K I	21. Signature of Funeral Service Licens	o Victor Pa	Woodlawn Doda, Jr. 2	harles L. S 501E. Fort	evens Fun Evenue, Ba	eral Home. Itimore Mi	^I 21230	
8760,	cate be executed / Medical / Medical and physician and physician and the brutal-transit	al Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	er the mode of dying	, such as cardiac	or respiratory arr	951,	Approximate Interval Between Onset and Death
.O. Box 687	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
4	Se un e	b	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did tol		to the cause of death? Probably 4 DUnknown
Records,	e law has b je 2 st	Completed						24a. Was a autops perform	sy prior to	
Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	th (Check only on		
f V	di is	To B	examiner? 1XXYes 2 □ No	Hospital: 1 🗌 Inpatie			4 Nursing H	ome 5 🕅 Reside	ence 6 □Other (Sp	ecify)
n of			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Mon h, Day	ry 28b. Time o y Year) Injury	28c. Injury Work			ow injury occurred	_
sio	Attending Pr r death. sctor: After th by the funeral	catl	2 Accident investigation 3 Suicide 6 Could not be	1019104	6:40	A M 1 TY	es 25 No		- HANGED SI	
Division	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	4 Homicide determined	28e. Place of Injuber building, etc.	ury - At home, farm, str c. (Specify) VC i			City or Town	treet and Number or I	Rural Route Number,
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical (of my knowledge, deat examination and/or in					
N	To the To the compl	Me	29b. Signature and title of certifier	1 /		29c. License	number CME		9d. Date signed (Moi OCTOBER 10	
			30. Name and address of person who c				Paltimos	mary 1	land 21201	
	Sta	ate	JACK M. Tit	2004 32. Regist	ar's Signature	g Span		e, mary	Land 21201	
ľ	Regist	rar	00114	-007	_	jajour	S.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10/10/04 **Physician** Norman Coldberg © 20:00 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hosp. Westminster, MD Carroll County 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Feb. 16,1946 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 152–36–5718 6. Sex 9. Birthplace (State or Foreign **Funeral** Country) 58 Months Days Hours XXM 2□F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "natural", or Items 23a or 286-f show traumatic event, the Mudical Examiner must be motified at 10d. Inside City Limits MD Carrol1 Sykesville 5 1 2 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7509 Second Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2/12/No f Yes, Give 1 Never Married 2 Married 1 Yes XXNo Specify: Specify: White à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12 N/A Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Be Herman Goldberg Betty Winick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Goldberg / Brother If Item 27 I 45 Mullarkey Drive West Orange NJ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baron Hirsch Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 18, 2004 Staten Island ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Average, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Densis /Medical Examiner P Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit ancer Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death Ö detached 9 Unknown 9 Unknown þ ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 8 Schizophene annid 2 No 3 Probably 4 □Unknown Completed nemia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Depatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 2 1 Tyes 2 ER/Outpatient 3 DOA in by the funeral 27. Manner Ceath 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 atural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide within 24 hours e 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 349

Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2004

Sementa 32. Registrar's Signature

10-0054218

Malenin drive, Westmenty

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3020 Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yeer **Physician** 21:34 M 2004 octobe 11 1490 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Johns Hopkins Hospital N/A6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Yrs. 430-34-0993 Director 76 ЛІ 11. 1928 Texas Usual Residence of Decedent with the Maryland 10d. Inside City Limits I Hygiene.
I Hygiene.
I other then "natural", or items 23a or 28a-1 show tother then "natural", or items 23a or 28a-1 show went, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director Merrimac Wisconsin Sauk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S 7642 High Point Drive 53561 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1953-56 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) Professor of Speech Pathology 5+ University d 2 should be filed w h and Mental Hygier ? Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lola Pauline Brewer ဂ္ Hugo Harris Gregory, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 Is any injury or other trau 2006. Carolyn B. Gregory, Wife 7642 High Point Drive Merrimac, WI 53561 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/13/04 Baltimore, MD 21. Signatur of Fun ral Service Licenses 22 Cremation Society of MD, Inc. Edward A //Gregorchik 299 Frederick Road Baltimore 21228 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-fran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the aftending physicien Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ cate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed 1 Yes 2 10 16 or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 L patient Certification: To 1 Tes 2 100 3 DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Affer Injury 5 Pending 1 🗌 Yes death. investigation 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) Street Baltimore Mn CON 600 N. MM T/Exande/ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 1 4 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** largare ant Tetober 12:50 PM /Medical 4a-Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner ESTVILLE 1 Year | If Under 24 George's narylano If Under 1 Social Security Number 6. Sex 8. Date of Birth **Funeral** 240-70-09 Days Min. 1 M 2 V F Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other then "neturel", or items 23e or 28a-f show treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Forestville 1 ☐ Yes 2 ☐ No Director Georges 10e. Street and Number 10g. Citizen of What Country? death with 3325 Walters Apt. 203 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Interest of Health and Mental Hygiene. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Black by Specify: 31 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laitress Oth Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Minnie Lurtis oummers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Gelston -Sister inda oummers Balto, mo 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation S☐ Other (Specify) permit. Page Department of Importent: If any injury or injury or Cemetery 10-15-04 Lansdowne MD 4 Donation 21. Signature of grand Address of Facility of Funeral Home P.A. Fredhilton Pass Balto., MD 21229 23a. Parti Enier ne disease, shock, o' heart failure. L e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death arrest Immediate Ca se (Final disease or distribution resulting in death) bulmoura Carelio Physician /Medical Due to (or as a consequence of): Examiner ock Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 di seen Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Cher (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ÛVnknown Completed Diale 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 \ No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 ☐ N 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After t Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) DΖ 30. Name and address of person who com pleted cause of death (Item 23a) (Type, Print) 106 IRVING STI TIW, SUITE-31. Date filed (Month, Day, Year) State OCT 1 4 2004 Registrar

Graham Grassick 04-06086 DOS

the Maryland

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician September 21, 1055 a ^M 2004 Graham Grassick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5201 Park Heights Avenue Apt A-10 Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Nov 24, 19 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 unk Funeral Days 1 X M 2 □ F 55 1948 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 la marked other than "natural", or Itama 23s or 28s-f ehow other traumatic evant, the Nedical Exactiner must be rotified at MD 1 Yes 2 □ No Baltimore Funeral Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 2 any Injury or other traumatic event, the Medical Ever it art must be reporte. 5201 Park Heights Avenue #A-10 21215 USA 14. Race - American Indian, Black, White, etc. unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) unk College (1-4or 5+) horse racing unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) OCME 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State `4□Donation 5፟፟MOther (Specify) in state Signature of Funeral Service Licensee Ronald S. W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic cardiovascular Priysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consaquence of) Examiner use as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown alcoholism Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 X Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certification that Funaral Directors. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) at SCENE 0 1 XYes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 22, 2004 OCME m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID 111 Penn Street, Baltimore, Maryland 21201 CI LING 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

OCT 1 4 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NATHAN SRUZ Month 2:40 AM OCTOBER /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NORTHWEST HOSPITAL RANDACESTOWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. A UG. 4, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) RUSSIA **Funeral** 1 M 2 □ F Months 85 Yrs. Director 217-09-6491 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Modical Experiment was be notified at Director N/A BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5817 MERVILLE AVENUE 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WWII If Yes, Give Year or Dates: ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or itel may injury or other traumatic event, the Modifical Exaction and any injury or other traumatic event. Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST PHARMACY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GRUZ **JACOB** MEDWEDEFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) URSULA GRUZ / WIFE 5817 MERVILLE AVENUE - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State CHIZUK AMUNO ARLINGTON 10/12/2004 ⁴ □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Saving Limnse 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the diseashock, or heart failure Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician SEPSIS /Medical Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? al or Attending Physician: T s after death. It Director: After this certifical 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 🗌 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital or within 24 hours af To the Funeral D 29a, Certifier 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. OLTOBER 9 D57722 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 OLD COURT ROAD LEONARD RICHARDSON RANDALLSTOWN, MD 21133 31. Date filed (Month, Day, Year) 4 2004 32. Registrar's Signature State Registrar HOUGE

			1 - For Stata Registrar	State of M	aryland				ealth a D <i>eath</i>	and M	ental Hy	giene Reg. No	0001	22520	
	Physici /Medic		1. Decedent's Name (First, Middle, Last George W. Headle								2. Date of De	aath 11 Day	^y 2004 ^{Yea}	3. Time of Death 8:56 am M	
	Examin		4a. Facility Name (If not institution, give National Lutheran Hom	е				Rock	ville	Maryla				Path Montgomery	
	Funeral Director		5. Social Security Number 355–10–8039 6. Se	X 2□F 7.A	ge (In yrs. la 88	ast birthday) Yrs.	Months	Days	If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 08/12/19			rth ay, <i>Year)</i> /191(9. Birthplace (State or Foreign Country) NJ		
	aryland show	7	Usual Residence of Decedent 10a. State 10b. County	gomery	10c. City	r, Town or Lo	cation	Rockville						10d. Inside City Limits	
	vith the M. or 28e-1	Directo	10e. Street and Number 9701 Veirs Drive	dower A			10f. Z	p Code	2085		Ī		izen of What o		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28e-f show amy injury or other freumatic event, the Madical Examinar must be multified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces 1 Yes 2 If Yes, Give	Armed Forces? If ` 1 ⊠Yes 2 □ No		f Yes, sp	Nas Decedent of Hispanic Origin? (Specify Y Yes, specify Cuban, Mexican, Puerto Rican,			city Yes or No Rican, etc.)	s or No- ltc.) 14. Race - Ame Black, White Specify:			
Maryland 21215-0036		Completed t	15. Decedent's Ed. (Specify only highest grad	ıcation	5+)	(Give	kind of w DO NOT	lent's Usual Occupation kind of work done during most of working DO NOT use retired) Of Audio Visual					ind of Busines	· ·	
land 2		To Be Co	17. Father's Name (First, Middle, Last) George W. Head	ley, Sr.					18. Mothe		ne (First, Middle, Maiden Surname) Mayme Kober				
Mar			19a. Informant's Name/Relationship (T) Tracy Solheim /		.1d	19b. Mailing Address (Street and Number or Rural Route Number, City 10 Midsummer Court, Gaithersburg						rg MD 20878			
Baltimore,			1 Burial 2 Cremation 3 Aremoval from State 1 Donation 5 Other (Specify)								elverton	or Town, State			
Balt	permit. Departr Importe eny inji		21. Signature of Funezal Service Licens	•• Victor P	Doda,	- I Cm	arles	L. St	evens	Funera	al Home,	Inc.	21230		
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
	/Medical Examiner			b											
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as								-			
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of d Month	elivery Day Year			
	juires that n signed b ıld be deta	d by Pr	Part II. Other significant conditions co	ntributing to death	but not resu	ilting in the ur	nderlying	cause give	n in Part I.			obacco u Yes 2(to the cause of death? Probably 4 2 Unknown	
Division of Vital Records,	sician: The law require certificate has been sid irector, page 2 should b	Completed	Chronic ob	strue tid	e F	ou Im	one	y c	dise	a se	24a. Was autop perfo		prior to	autopsy findings available o completion of cause of	
Zita ∑ita	ilcian: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
o	Phys or this oral di); To	1 Yes 2 No	28a. Date of Ini	urv	ER/Outpatien 28b. Time of		28c. Injury Work	4 (5) (8) (1)		ie 5 □ Resi 8d. Describe I		S Other (Sp y occurred	pecify)	
/ision	To the Hospitel or Attending Physician: The within 24 burs after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification;	Natural 5 Pending investigation 5 Suicide 6 Could not be determined	(Month, Da 28e. Place of in building, e		Injury me, farm, str	М	1 🗆 \	:? ∕es 2 □ N					Rural Route Number,	
Ö	spitel or cours afte nerel Dire		4 ☐ Homicide 4 ☐ Homicide 29a. Certifier 1 ☐ Certifying Phy						e, date and	d place a	City or Tov			as stated	
	he Hos n 24 h he Fur pletely	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner s	of examinati	ion and/or inv	estigation	n, in my op	inion, deat	h occurre	d at the time,	date and	place, and di	ue to the cause(s)	
	To t To t	Σ	29b. Signature and title of contifier	mell	- m	P	29	c. License	number	12				nth, Day, Year)	
	n		30. Name and address of person who can Maller MD, 9701	ompleted cause of Veirs Drive	death (Item	^{23a)} (Type. Ville M	Print) 1D 208	50						· · · · · · · · · · · · · · · · · · ·	
Ì	Sta		31. Date filed (Month, Day, Year)		par's Signat		9	Soon	KN	·					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death **Physician** 2004 Hawkins-Scott 3:50 PM 0 e /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) Examiner Nursing Home orest Haven atonsuille altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 9. 6. Sex 1□M 2**X**F **Funeral** Hours Days Months Yrs. 96 434-44-4587 Usual Residence of Decedent LA Director filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show th end Mentel Hyglene. 7 is marked other than "naturel", or Hema 23a or 28e-f sho traumetic event, the Medical Examiner must be notified al 1 □ Yes & No Funeral Director Pikesville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 8122 Scotts Level Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify. ģ 3 Widowed 4 □ Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Private 12th grade 17. Father's Name (First, Middle, Last) 2yrs 18. Mother's Name (First, Middle, Maiden Surname) and Mentel Peges 1 and 2 should be Emily Baptiste Phillip Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) if item 27 is Doris E. Scott-Daughter 8122 Scotts Level Rd., Pikesville, Md 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Depertment of important: If any injury or pace. Arbutus Memorial Park 10/16/04 Arbutus, Md 21. Signature Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md ft1. Enter the Nsease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. 21215 Approximate Physician firmediate Cause (Final disease or condition resulting in death) /Medical Megis Examiner Physician/Medical Examiner 101 00 ettending physician and for use es the bunal-transit Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No a cordent To the Hospital or Attending Physician: The lew requires t within 24 hours after death.

To the Funeral Director. After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed TOYES 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier matin H Masem MD

Registrar

DHMH 16 Rev 6/95

State

AMA

31. Date filed (Month Day, Year)

DO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 2004

MAREM 501

32. Registrar's Signature

			For State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death								
			Registrer 1. Decedent's Name (First Middle, Las	st)	Certifica	ate of Death	Reg. No. 2. Date of Death 3. Time of					
	Physici /Medio		EDIT	H OLIVIA	HIN-	toN	Month	12 ZCC	4 220 pm			
	Examir		4a. Facility Name (If not institution, give UNION MEMI	street and number)	4b. C	ity, Town, SLocation of De	IORE	4c. County of De	eath			
	Funeral Director		10.10.00	ex ☐ M 2 P F 7. Age (In yrs. la	Yrs. ff Un	der 1 Year If Under 24 H hs Days Hours Mi	8. Date of B	8. 423 M	Sirthplace (State or Foreign			
	Aaryland show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	105			10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
	with the Page or 28s-	i Direct	10e. Street and Number	W WOOD A		Zip Code 2174)	9	10g. Citizen of What	Country?			
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, the factor of 18 marked other than "natural", or Items 23e or 28e-f show other traumatic event, it is Madical Exercities.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No		cedent of Hispanic Origin? specify Caban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	lo- 14. Race - Ar Black, WI	nerican Indian, hite, etc.			
215-0036	72 hours a natural, c	eted by	3 Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest gra	If Yes, Give Year or Dates:	16a. Decedent's U	s 2 No Specify: Isual Occupation work done during most of w	endring	Specify: 1	SINGUSTRY			
2	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired) LERK		GOVERN	MENT			
Maryland	should be fill and Mental H is marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) KOBERT JO	HNSON		18. Mother's N	ame (First, Midd)	ARISH				
_	ss 1 and 2 sho of Health and item 27 is my r other trauma		19a Informant's Name/Relationship (SON	514 Y	ss (Street and Number or I	AVE.	BALTO, M	D 21209			
Baltimore,	Page nent o ent: If ury or		20a. Method of Disposition 1 Narial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	nce of Disposition (I	or other place) EMETERY 10	Date 9-19-04	ARBUTUS,	MARYLAND			
Ball	permit. Pag Department Importent: I any injury o	N S	21. Signature of Funeraf Service Licen	la Stelle	4905	and Address of Facility V	AUCHA BA	UTIMORE.	NE FUNERAL MD 21212 HA			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each fine. a. Uros eps i s Due to (or as a conseque		node of dying, such as cardi	ac or respiratory	arrest,	Approximate Interval Between Onset and Death HS hours			
8760,	icate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)								
P.O. Box 687	The law requires that the death certificate title has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 No 9 ☐ Unknown	d. 23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 □Ectopio	c pregnancy (specify)		23d. Date of d Month	elivery Day Year			
	w requires that been signed b should be deta	d by Pł	Part II. Other significant conditions of	ontributing to death but not result	ting in the underlyin	g cause given in Part I.		tobacco use contribute	to the cause of death? Probably 4 □Unknown			
al Records,		Completed by					24a. Wa auto perf 1 🗆 Yes		autopsy findings available completion of cause of s			
Vital		To Be	25. Was case referred to medical examiner? 1 Yes No	Hospital: ↑ Inpatient 2☐ E	R/Outpatient 3□	Other	eath <i>(Check only</i> Home 5 ☐ Res	one) idence 6 ☐Other (Sp	necify)			
ion of	Attending Physic death. ector: After this by the funeral di		27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred				
Division	i Ditte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, fact	tory, office	28f. Location City or To	(Street and Number or I own, State)	Rural Route Number,			
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai (29a. Certifier (Check only one) Certifying Ph 2 Medical Exen	ysicien: To the best of my knowniner: On the basis of examination and manner stated.	ledge, death occurr on and/or investigati	ed at the time, date and placion, in my opinion, death occ	ce, and due to the curred at the time	cause(s) and manner and date and place, and da	as stated. ue to the cause(s)			
	To th withir To th comp	Me	29b. Signature and title of certifier	00 4:5		29c. License number		29d. Date signed (Mor				
			Chandelle			ump 1875		10-12-2	2004			
	9		30. Name and address of person who	completed cause of death (Item): $A D B B B B B B B B B B B B B B B B B B $	V Parkw	ay Baltin	iore. M	D				
:	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar's Signatu			101 -1					

		FOR	•	partment of Health and I	Mental Hygier	ne	
		1 = State Registrar		Pertificate of Death	Reg. I	No.2	3253
Physici	an	1. Decedent's Name (First, Middle, Last)	NA.	MPTON	10	Day Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Death	SEPTEMBE	1C Z1 Z004 4c. County of Deeth	
Examir	ier	Northwest Horoval	CANTER	Randa 115tow,		Baltima	
Funeral		5. Social Security Number 6. Sex 7	7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 11,	ar) 9. Birth	place (State or Foreign intry)
Director		266 32 306 10M 2XF	76 Yrs	5.	March 11	,1928 Mi	ami,FL
and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location			10d. fnside City Limits
Maryl -f sho	to	MD Baltimore	Randa:	llstown			1 ☐ Yes 2 XNo
n the	irec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
ING Z I Z I 3-UU.30 be filed within 72 hours atter death with the Maryland tal Hygiene. d other then "natural", or items 23a or 28a-f show event, the Madical Examiner must be nutified at	Funeral Director	20 Sunrise Court		21133		USA	
tems	nuel	Armed For		 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - Amen Black, White	
OUGO hours afte ural; or i	by F	1 Never Married 2 Married 1 Yes 3 If Yes, Give 3 Widowed 4 □ Divorced Year or Da	9	1 ☐ Yes 2 SNo Specify:		Specify: Bla	ack
within 72 hours after ene. then "natural", or ite	ted	15. Decedent's Education	16a. De	ecedent's Usual Occupation	16b	. Kind of Business/Ir	ndustry
Med n	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-		Rive kınd of work done during most of wor fe. DO NOT use retired)	king	. 10 200	
d Z I.	Completed	17 2		Receptionist		Newsa	aper
	Be	17. Father's Name (First, Middle, Last) Ezekial Moncur			ne <i>(First, Middle, Mai</i> d de Dod i e	len Sumame)	
larylan 2 should be and Mental Is marked eumatic ev	은	19a. Informant's Name/Relationship (Type, Print)	19h M	lailing Address (Street and Number or Ru		ty or Town State Zi	in Code)
Mal nd 2 st allth and 27 is n r treun		Arnold Hampton /Son		Sunrise Court, Rand			p Code)
רי, בְּשֻׁ בֵּשָׁ בַּ		20a. Method of Disposition	20b. Place of Di	isposition (Name of	Date 20c.	Location - City or T	
Baltimor permit. Pages Department of I important: If It eny injury or o		1 □ Burial 2 □ Cremation 3 M Removal from S 4 □ Donation 5 □ Other (Specify)	Washing Cemet	ton Park East 9/25	5/04 II	ndianapol:	is,IN
Baltimor permit. Pages Department of Important: If It eny injury or o		21. Signatur of Funeral Service Licensee	Center	22. Name and Address of Facility Charles L. Stevens	- Funeral 1	Home Inc	
		124 4 70		1501 East Fort Ave	e. Baltimo	re MD 212	
		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	ach line.				Approximate Interval Between Onset and Death
Physician		fmmediate Cause (Final disease or condition resulting in death)	enoscless	YIC COLONOLY VA	navlan Di	sease	Onsor and Doam
/Medical Examiner		Due to (c	or as a consequence of):				
	-F		or as a consequence of):				
pe d	Exan iner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			or as a consequence of):				
os / 60,	dicai	d					
ortifica ing pt	Med	IF FEMALE:					
BOX 61 Bath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	come of pregnancy rth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	very Day Year
ched the G	ysic	1 ☐ Yes 2 ♠No 9 ☐ Unknown	ant at time of death	5 Other (specify)			
Cords, P.O. *requires that the dependence of the detached should be detached.	by Physician/Me	Part II. Other significant conditions contributing to de	ath but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
rdS quires n sign	q pe	Hyportension			1 🗆 Yes	2 No 3 Pro	bably 4 M Unknown
Hecords, he law requires t e has been signe age 2 should be	Completed	Cerebrovascular	Acciden	H	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
The law rate has page 2 s	E O	HyperlipidemiA			performed	? death?	
r Vital F ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical			ath (Check only one)		
Of V Physic r this coural dire	P		npatient 2 2 R/Outpa		ome 5 Residence		ify)
ISION C trending P death. tor: After I the funera	ion:	1 polyatural 3 1 origing	of Injury 28b. Tim h, Day Year) Inju		28d. Describe how in	ijury occurred	
DIVISION I or Attending after death. Director: Afte	fical	3 Suicide 6 Could not be determined 28e. Place	of fnjury - At home, farm		28f. Location (Street		ral Route Number,
DIV all Dire	Certification:	4 Homicide determined buildin	ng, etc. (Specify)		City or Town, St	ate)	
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the	best of my knowledge, d	feath occurred at the time, date and place or investigation, in my opinion, death occurred.	, and due to the cause	(s) and manner as	stated.
the H nin 24 the F nplete	Medicai	one) and mann	er stated.				
To To	-	29b. Signature and title of certifier		29c. License number	290.	Date signed (Month,	, Day, Year)
		M. Menguo	o of death (New 22-) T	DCU35441	- 1	121104	
		30. Name and address of person who completed cause	5401 Old		whallet in	nml =	1133
St	ate		egistrar's Signature	Sant a	I WATE I WATER	11140 6	1
Regist		OCT 1 4 2004	new so	aberen.			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 00500 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 10,2004 4:30 РМ Holland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Lorien Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adonths Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 76 Vrs 220-22-8912 PA. Director September 5,1928 Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State or than "natural", or items 23s or 28a-f show the Madrest Examiner must be notified at Dundalk 1 ☐ Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 LISA 8237 Dundalk Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If ten 27 is marked other the any injury or other traum. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Schaffstall Thomas Bowerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8237 Dundalk Avenue, Dundalk, Md. 21222 Husband James Holland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 14, 2004 Halethorpe, MD `4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Funeral Service Licens en5 7110 Sollers Point Road, Dundalk, Md. 23a. Pm11 Enter the disease, or complications is a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, now, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm die te Cause (Final disease or condition resulting in death) Bacterial Preumons Physician /Medical Due to (or as a consequence of) Hegrestension.

Diabeles Mellitus. Examiner scentia, Sequentially list conditions Sequentially list condition any, leading to immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (qr as a consequence of) Examiner on let attending physician and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1□ Yes 2☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 13 2004 El mu D 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt) Live Neck Road Balhmore Maylay 21221 201-109 Jahapalhi Kamech 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 1 4 2004

		-	For State Registrar	State of Maryland		artment of F <i>tificate of</i>		and Menta	l Hygier Reg. 1	21101	32533
			1. Decedent's Name (First, Middle, Last)					2. Date Mor	e of Death	Day Year	3. Time of Death
	Physicia /Medid	al '	Vivian Howard							004	12:55 P ^M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		of Death		4c. County of Deat Prince Ge	
			Southern Maryland 5. Social Security Number 6. Sec		ast birthday)	If Under 1 Year	If Under 2	24 Hrs. 8. Date	1		holace (State or Foreign
	Funeral Director			M 2MF 59	Yrs.	Months Days	Hours	Min. (Mo	e of Birth nth, Day, Ye. 22,	1945 Was	shington,DC
	pu ,		Usual Residence of Decedent 10a, State 10b, County	10c Cib	, Town or Lo	eation					10d. Inside City Limits
	shov	'n	MD Prince Geo		mple I						1 ∑Yes 2 ☐ No
	the M	ect	10e. Street and Number	7.90	111720 1	10f. Zip Code	<u> </u>		10g.	Citizen of What Co	ountry?
	3a or	io i	3239 28th Parkway	7		2074	18			USA	
	death	nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	lispanic Orig	gin? (Specify Ye	s or No-	14. Race - Ame Black, Whit	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 💢 No	Specify:				3lack
2-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done	during most	t of working	16b	. Kind of Business/	'Industry
2	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d)			ent of i	Agriculture
i D	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)		Stat	istical	18. Mothe	er's Name (First,			Agricured
au	ld be ental ked o ic eve	To Be	Unknown				Ma	ry D. S	tewart		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Ty							ty or Town, State, 2	Zip Code)
	and 2 salth a n 27 I		Lisa Jenkins-DeP							MD 20735	
Baltimore,	ges 1 of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	emovai irom State		sition (Name of matory or other pla	- 1	Date		. Location - City or	
Ë	i. Pag tment tant: jury		'4 □ Donation 5 □ Other (Specify)			tion Cem.		10/13/0	and the same of th	Clinton, I	
Ba	Depar Impor any ir		21. Signature of Funeral Sentic Life	reflere						uneral Songs, MD	
			23a. Part. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the death ne cause on each line.	n. Do not ent	er the mode of dyi	ng, such as	cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	METAST	ATI	C BR	EASI	CAR	CEN	OMA	Olisar and Death
	/Medical- Examiner		resulting in death)	Due to (or as a consequence	uence of):					80	
		er	if any, leading to immediate	Due to (or as a consequ	uence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	cate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	ate be hysici the bu	dical		d							
9	entific ding p		IF FEMALE:	3c. If yes, outcome of pregna	Incv					23d. Date of de	livon
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s, P	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	. 23	e. Did tobacc		the cause of death?
ord	w require been sig should t								1 🗆 Yes	2 □ No 3 □ Pi	robabły 4 B Unknown
Vital Record	e law r has be je 2 sh	ompieted						24	a. Was an autopsy	prior to	utopsy findings available completion of cause of
= ====================================	Th ate pag	Con						1	performed Yes 2		2 □ No
Vita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot	hor	of Death (Chec		- 700 (0	
of		1: To	1 ☐ Yes 2 ♠ No 27. Manner of Death	28a. Date of Injury	28b. Time o	" 3 DOA	4 🗀 140			e 6 Other (Spe	city)
lon	Attending Phir death. ector: After thiby the funeral	ation	1 ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury		rk?]Yes 2⊡l	No			
Division	II or Attendi after death. I Director: A d in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)		reet, factory, office			cation (Street y or Town, S		ural Route Number,
Ö	ital or rs afte al Dir	Cer		3,,							
B	To the Hospital of within 24 hours at To the Funeral Completely filled in	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.							
1	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen				Date signed (Mont	
			> Shoul Hour	- and		D5	086	2	0	CTOBER,	7,2004
	Q_{j}		30 Name and address of person who o	ompleted cause of death (Item	п 23а) (Туре,	Print)		/ 1	117	20701	
			Hassan Sheric, 1	11. 983 Livee	nbelt,	Kd. Suite	103,	Lanham	, M.D.	20106	
•	St Regist	ate rar	Hassan Sherif, 1 31. Date filed (Month, Day, Year) OCT 1 4 2004	trace It	Los	K)					
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			1 - For State Registrar	State of Marylan	•	artment of H <i>tificate of L</i>		, ,	giene Reg. No. 🔿 🔘	01 6	
İ	Physici /Medic		1. Decedent's Name (First, Middle, Las BENTHA	10 11	HARDY			2. Date of Dea Month	Day 20	Year 1	Time of Death
X	Examir		4a. Facility Name (If not institution, give No IRTH ARUN 5. Social Security Number 6. So	DEL HOSPI		4b. City, Town, or CLEN If Under 1 Year	Burn	12	4c. County	17-14	(State on Foreign
	Funeral Director		215-22-8928 1	□ M 21 F 78	Yrs.	Months Days	Hours Mir		/ Vear	9. Bittiplace Country) MD	(State or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne A	State 10b. County 10c. City, Town or Location						10d. Inside City 1 ☐ Yes	
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?	
36	s after death v or items 23e	Funerai	122 North Bend Te 11. Marital Status 1□ Never Married 2⅓ Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give		2106 Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No- rto Rican, etc.)		U.S.A. e - American III ck, White, etc.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examination must be notified at once.	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Deced (Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	turing most of we	orking	16b. Kind of Bu	usiness/Industr	ry
		To Be Cor	17. Father's Name (First, Middle, Last) 18. Mother's Nam					ame (First, Middle, Le Pawlow			ırant
, Maryland		-	19a. Informant's Name/Relationship (1	ype, Print) ore / sister	1621	g Address (Street a		Curtis Ba			fe)
Baltimore,	Pages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Mea	emetery, cren adowr i c	sition (Name of natory or other place) lge Mem.	Park 200		Elkrid	ge, MD	
Balt	permit. Depart Import any inj		21. Signatur of porat Service Licen	5 mo1319	1	. Name and Address Second A	venue S.	W., Glen	Burnie	, MD 21	.061
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence)	-s/	1		C IN		Inte	proximate erval Between set and Death
8760,	Exaa be executed by sicial and burial-transit sthe burial-transit	dical Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence) Due to (or as a consequence)	2 7 T T Juence of):	SUS	SHOL	CING		35	SYEARS SYEARS
O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	FFEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2No 9 Unknown 9 Unk								23d. Date of delivery Month Day Yo	
۵.	w requires that been signed b should be deta	by	Part II. Other significant conditions or	ontributing to death but not resu	alting in the ur	nderlying cause give	on in Part I.		bacco use contr es 2 \(\square\) No	ibute to the ca	
Vital Records,	iician: The law requ certilicate has been rector, page 2 shouk	Completed						24a. Was a autops perform	med? d	Vere autopsy forior to complete leath?	indings available tion of cause of
Z Z	ysician is certifi director	o Be	25. Was case referred to medical examiner? 1 \sum Yes 22 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA Othe	r	ath <i>(Check only on</i> Home 5 \(\subseteq \text{Reside}	***	ar (Specify)	
Division of	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho			
DİXİ	ital or Attendins after death ral Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specify	")			28f. Location (St City or Town	n, State)		
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	Medical	one)	vsician: To the best of my know inner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	estigation, in my op	inion, death occ	e, and due to the caurred at the time, d	ause(s) and ma ate and place, a	nner as stated and due to the	cause(s)
	To the To the Comple	2	29b. Signature and title of certifier	2 8 (1)	MD		2519	•	9d. Date signed		
	1	l li	30. Name and address of person who con the control of the control	FISHERZ	23a) (Type, I	Print) PENN	INGT	ON AV	E, B	ALTI	X H MORE
	Sta	ite	31. Date filed (Month, Day, Year)	52. Registrar's Signat	ure	-			1		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician Louise Emma Hoffman 2004 October 11:55p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Westminster Carroll Summerville 5. Social Security Number 213-01-7939 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 8 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Months 93 Hours 1 □ M 2 💢 F 1911 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

ther then "natural", or iteme 23e or 28a-f show 10a, State 10b County 10c. City, Town or Location 10d Inside City Limits r then "natural", or iteme 23e or 28a-f show the Medical Examiner must be notified at Md Carrol1 Marriottsville 1 ☐ Yes 2 → No Director 10f. Zip Code 21104 10g. Citizen of What Country? 10e. Street and Number ŬSA 7285 Ridge Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry clerical Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 ie marked other any injury or other treumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last)
William Sissellberger Be Florence M. Ghor 19a. Informant's Name/Relationship (Type, Print)
Shirley A. Slate (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7285 Ridge Rd., Marriottsville, Md 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 10-12-04 Baltimore, Md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee any ir I tage Haight Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician inscherater /Medical Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to für as a consequence off Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 KNo this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only one) and manner stated 29c. License number 29b. Signature 2 ise of death (Item 23a) (Type, Print) 30. Name and dress of person who completed cay 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13 Month Year **Physician** Elinor R. Hemstetter 10 2004 11:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Mariner Health of North Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 3/13/1916 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 □XF Days Hours 88 Director 214-22-3054 Baltimore, MD Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Items 23a or 28a-f show other traumatic avant, Its Modical Examinations and the confidence of the contract of the c 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Emerson Avenue U.S.A. 21061 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3x□ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerical 12 should be filed w h and Mental Hygier 7 Is markad other th Westinghouse - BWI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jesse Sipes Bertha Broglie ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 so to of Health an If itam 27 ls 1 7 Emerson Avenue, Glen Burnie, MD 21061 William Munck Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) Glen Haven Cemetery | Oct. 15 Glen Bunie, Maryland 21. Signature of Funeral Service Johnse 22. Name and Address of Facility DUC. Stallings Funeral Home, P.A. Pasadena, MD 21122 3111 Mountain Rd., 23a. Part. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician serventia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the t IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? φ Month Year Day 4 Pregnant at time of death 5 Other (specify) the o à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 1002 1 Yes 2 No 3 Probably 4 Wunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate Division of Vital 1 🗌 Yes 2 No 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☑ No 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral D † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number october 13th 2004 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oakwood Road MA 21061 7845 alon Bernie K. Ambalavanar, OCT 1 4 2004 32. Registrar's Signature 31. Date filed State Registrar

		-	For State Registrar	State of Ma	aryland				lealth a Death		F	leg. No.	004	325	37
	Physicia	_	1. Decedent's Name (First, Middle, Las	t)	HIL	1					2. Date of Dea Month CTOBER	Day	Year	3. Time o	
	/Medic	al	4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of		CIODER		County of De		
\$	Examin	er			CENT	TER	BAI	TIMO	ORE				N/A		
	Funeral		5. Social Security Number 6. So	9x 7. Ag	e (In yrs. las		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birti (Month, Day	, Year)	9. B	rthplace (State	or Foreign
Ь	Director		241-32-6733	LIM ZEAF	79	Yrs.					March 2	25 19	925 N	ORTH CA	ROLINA
	and w	1	Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside (City Limits
	Maryl -f sho	to	MARYLAND N/A			BALTI	MORE							¹ X∑X Ye	s 2 No
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	Country?	
	or deeth with the Marylan tems 23e or 28e-f show er meat the modified at		3633 REISTERS	rown RD.				215					S.A.		
	er deeth w Items 23e	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced If Yes, spec	dent of H cify Cuba	ispanic Orig an, Mexican,	in? (Spec , Puerto P	cify Yes or No- Rican, etc.)	1	4. Race - An Black, Wh	erican Indian, ite, etc.	
36	hours after deeth with the Maryland tural', or Items 23a or 28a-f show at Examber mast be notified at	by F	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 □ Yes 2 XX If Yes, Give Year or Dates:	No		1 🗆 Yes	2 X XN0	Specify:				Specify: B	LACK	
21215-0036	i within 72 hours afti liene. r then "natural", or l ir a Medical Exert		15. Decedent's Ed	lucation		16a. Dece	dent's Usua	al Occup	ation	-4		16b. Kin	nd of Busines	s/Industry	
215	within 72 ene. then nat	ple	(Specify only highest gra	de completed) College (1-4or :	5+)	life.	DO NOT u	se retired	during most d)	or workin	ng				
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nd	e d la b	Be	17. Father's Name (First, Middle, Last)						18. Mother	rs Name	(First, Middle,	Maiden 3	Sumame)		
Maryland	Me Me	은	unknown 19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	na Address	(Street	unkn and Numbei		Route Numbe	r, City or	Town, State,	Zip Code)	
Ma	nd 2 sho lith and 27 is m		Ethel L. Couser/								Baltin				
re,	s 1 and 3 f Health item 27 other tra		20a. Method of Disposition	_	20b. Plac	ce of Disponetery, crei	sition (Nar	ne of		Da	ate			r Town, Stete	
Baltimore,	Pages ment of l ant: If its ury or o		1 🗗 Borial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify			ZION	-			0-18	-04 1	ANDS	DOWNE	MARYL	AND
alti	permit. Pag Department Important: I any injury o		21. Signature of Fund el Service Xin Se	Ses		W T	2. Name ar	d Addre	ss of Facility	COMM	UNITY E	UNER	AT, HO	ME P.A.	
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6. 44	Physician /Medical Examiner	er	23a. Part. Emer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. CERL Due to (or as	ne. BRO a conseque ER T	nce of):	CUL	AR			DENT			Interval Be Onset and 2 YE	etween I Death IPRS.
68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	cDue to (or as	a conseque	nce of):									
P.O. Box 6	To the Hospital or Attending Physicien: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	eath 3	Ectopic p Other (sp		′			2	3d. Date of d Month	elivery Day	Year
	w requires that been signed should be def		Part II. Other significant conditions of BULL OUS	PEMPH	out not result	ing in the u	inderlying o	ause giv	ren in Part I.					to the cause of Probably 4	
I Records,	The law re ate has bee page 2 sho	Completed by									24a. Was autop perfo 1 Yes	sy med?	24b. Were prior to death?		s available cause of
Vital	ysicien: The Is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hamital.				Oth			(Check only o	-	-	10455	
of	ding Physi n. After this o funeral dire	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatio	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ary 2	R/Outpatie 8b. Time o Injury		28c. Injur Wor	4 (1401	2	ne 5 Resid			ecify)	
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	jury - At hom tc. (Specify)	ne, farm, st	reet, factor	y, office	fiene	2	8f. Location (S City or Tox			Rural Route Nu	mber,
	e Hospita 24 hours e Funera	Medical (29a. Certifier 1 Certifying Pt (Check only 2 Medical Exer	nysician: To the best niner: On the basis of and manner st	of examination	ledge, deat on and/or in	th occurred ivestigation	at the tir	me, date and opinion, deat	d place, a th occurre	and due to the e	cause(s) date and	and manner and de	as stated. ue to the cause	(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	,			1		e number	10				nth, Day, Year)	
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	St Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signatu	G	100	ethe	/						

		1 - For State Registrer	State of	Marylan		partment ertificate			nd Me	-	giene Reg. No.	004	32538
Physici /Medic		1. Decedent's Name (First, Middle, I	HE	225						2. Date of De	O Day	th Year 2004	
Examin	ier	4a. Fecility Name (If not institution, g	TAL CENTE	R		RAN	IDALLS				ВА	LTIMO	RE
Funeral Director		5. Social Security Number 213-01-8527 Usual Residence of Decedent	. Sex 1 □ M 2 □ F	Age (In yrs. I	a <i>st birthda</i> Yrs	Months		f Under 24 Hours	Min.	8. Date of Birt Month, Da MAY 23	,1919	9. Birt	thplace (State or Foreign ountry) MD
Maryland	tor	10a. State 10b. County	BALTIMORE		, Town or	Location KESVILL	.E						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
h with the	Funeral Director	10e. Street and Number 3800 OLD COURT	ROAD #109			10f. Zip (21208			10g. Citizer	n of What Co	USA
2 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28e-f show reumetic event, If a Modical Examiner must be notilified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	S? ØNo	S. 1	3. Was Decede If Yes, speci 1 \(\text{Yes} \) 2		anic Origir Mexican, F Specify:	n? (Spec Puerto R	cify Yes or No- lican, etc.)		Race - Ame Black, Whit pecify:	
d within 72 hours jiene. r then "neturel", ne wooles Ex	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4d	or 5+)	(G.	cedent's Usual ive kind of work e. DO NOT use OPRIETO	k done dur e retired)	on ing most o	of workin	_		of Business/	Industry COMPANY
s 1 and 2 should be filed if Health and Mental Hyg Item 27 is marked othe other treumetic event,	To Be C	17. Father's Name (First, Middle, La SAMUEL	st)			LVER		LEN	Α	(First, Middle,		RUE	BENSTEIN
os 1 and 2 shoft Health and Item 27 is m		19a. Informant's Name/Relationship MARLENE POLLAK			32	ailing Address 17 SMIT	H AVE		- BA	NLTIMOR			
Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		ate C	emetery, d	sposition <i>(Nam</i> crematory or otl AHAVAS	her place)	ED 1	0/13			tion - City or DALLST	Town, State
permit. Pages 1 Department of H Importent: If Ite any injury or ot		21. Signature of Fundamental Purising Lice	ensee	, , , , , ,	4	22. Name and							, INC. , MD 21208
Physician /Medical Examiner pruial-transit	ical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c	as a consequ	ASTB uence of): RIC uence of):	COINTE	STIM				rest,		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 55No 9 □ Unknown		n 2 ∏ Fetal It at time of de	death	3 □Ectopic pre 5 □ Other (spe					23d	l. Date of del Month	ivery Day Year
w requires that been signed b should be deta	by	Part II. Other significant conditions	s contributing to death	th but not resu	ulting in the	e underlying ca				23e. Did to			the cause of death?
eicien: The law re certificate has be- irector, page 2 shc	Completed	<u> </u>							_	24a. Was autop perfor 1 Yes	sy	4b. Were au prior to death?	topsy findings available completion of cause of 2 No
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	lon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending			ER/Outpa 28b. Time Injur		Other: 3c. Injury at Work?	4 🗌 Nursi	ing Hom	(Check only o e 5 ☐ Resid 3d. Describe h	lence 6		cify)
el or Atteno s after death il Director: ed in by the	Certification:	2 Accident investiga' 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	Injury - At ho , etc. (Specify	me, farm,	street, factory,			28	3f. Location (S City or Tow		lumber or Ru	ıral Route Number,
e Hospit 124 hour e Funere detely fille	Medical (Physician: To the be caminer: On the basis and manner	s of examinal									
To the within To the Comp	Me	29b. Signature and title of certifier	nam	7	10	29c.	License n	umber 428	8	;	29d. Date si	igned (Mont)	h, Day, Year)
V		30. Name and address of person w	to completed cause of	of death (Item	23a) (Ty	oe, Print)	Vort	nuc	1	Huen	top	On	43
Sta Regist		31. Date filed (Month, Day, Year) QCT1 4 2	32. Feg	istrar's Signa	ture	Loa	Ks/						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

PM 4-06598 loria Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stete Registrar	State of Marylan	•	tificate of L		-	gierie Reg. No.	2004	32539
	Dhysisis	20.0	1. Decedent's Name (First, Middle, Las.)				2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Gloria Johnson					Octobe	r 1	1, 2004	
7	Examin	er	4a. Facility Name (If not institution, give			-	Location of Death	1	4c.	County of Deeth	1
			Good Samaritan Ho 5, Social Security Number 6, Se	-	lact hirthday)	If Under 1 Year	ltimore If Under 24 Hrs.	8 Date of Bin	th	Q Rieth	place (State or Foreign
Н	Funeral Director		214-38-1418	M 20 F 63	Yrs.	Months Days	Hours Min.	8. Date of Bin (Month, Da 03/09/1	у, _{Үөаг)} 1941	Mary	place (State or Foreign intry) 1and
	land	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Many -f sh	to	Maryland	ļ "	Baltimo	ro					1 X Yes 2 ☐ No
	r 28e	Director	10e. Street and Number		JAICING	10f. Zip Code			10g. Citiz	zen of What Cou	intry?
	th with	alD	1509 Kingsway Roa	d		21218			U.S.	Α.	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S)	pecify Yes or No		14. Race - Amer Black, White	ican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show entry injury or other treumetic event, if a Medical Evat, car must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🟋 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1□Yes 2∏XNo				Specify: B1	
20	72 ho netur	Completed	15. Decedent's Ed	ucation de completed)	16a. Deced	tent's Usual Occupa	ation during most of wor	kina	16b. Kii	nd of Business/l	ndustry
121	Aithin ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)				
2	iled v lygie ther t nt, th		12 17. Father's Name (First, Middle, Last)		House	wife	18. Mother's Nan	ne (First Middle		lomemake	r
Maryland	d be a	To Be	Lewis Owens				Annie Ma				
IZ.	shoul nd Me mark meri	F	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street a			er, City o	r Town, State, Z	ip Code)
Z	alth a		David Johnson / So	n	3801	Wabash Av	ve., Balt	timore,	Mary	land 21	215
ore,	es 1 a of Hei		20a. Method of Disposition 1 Disposition 3	20b. P	lace of Dispo	sition (Name of matory or other place	e) 10/1	9/2004		cation - City or T	
Ë	Pagement ent: If ury o		`4 ☐ Donation 5 ☐ Other (Specify	Arb	utus M	em. Pk. C	eme.				Maryland
Baltimore,	permit. Depart Import eny inj		21. Signature of Funeral Service Licen-	(1)		Name and Addres					/H, P.A. land 21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· LAIMO		inoma					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a corseq							
	Examine	<u>.</u>	Sequentially list conditions,	b. Due to (or as a conseq.	uanaa aft						
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq.	uence 01).						
<u>.</u>	execunate and al-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of):						
68760,	flicate be executed g physician and as the burial-transit	edical Examiner		d							
	± 03 €		IF FEMALE.								
Вох	death certifi e attending id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			2	3d. Date of deliving	very Day Year
0.	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□ Pregnant at time of d 9□ Unknown	eath 5	Other (specify)				WORT	Day 16ai
Φ.	law requires that the as been signed by the 2 should be detache	y Ph	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
of Vital Records,	quires in sign uld be	ed by						1 🗆 '	Yes 2	No 3∏Pro	bably 4 Unknown
000	aw requir is been si 2 should	Completed						24a. Was		24b. Were aut	opsy findings available ompletion of cause of
R	0 = 0	mo						perfo	rmed?	death?	
Ha	ien: ertific ctor,	Bec	25. Was case referred to medical examiner?				26. Place of Dea				
∑ V	Physicien: this certific ral director,	2	1 XYes 2 □ No		ER/Outpatier	-	4 Nursing H	ome 5 Resid			fy)
n C	ling P	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	∕at ⟨? Yes 2 ∐No	28d. Describe !	how injury	/ occurred	
Division	death death stor: / the /	icat	2 Accident investigation 3 Suicide 6 Could not be		ome farm str		165 2 110	28f. Location (5	Street and	d Number or Bu	al Route Number,
Ď	after Direct	Certification;	4 Homicide determined	building, etc. (Specifi	y)	001, 140101, 011100		City or Tov			
	To the Hospitel or Attending Physic within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	edical C		ysician: To the best of my kno iner: On the basis of examina and manner stated.							
	To the To the	Me	29b. Signature and title of certifier	01.		29c. License	number		29d. Date	signed (Month	Day, Year)
			*XIIUV	W VVI		0	.C.M.E.		Octo	ber 13,	2004
			30. Name and address of person who	completed cause of death (Item		Print) Penn Str	eet, Bal	timore,	Marv	land 21	201
:	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 4 200	. Registrar's Sign							_

			For State	State of Marylan		nent of H cate of I		Mental Hy	giene		
	•		Registrer 1. Decedent's Name (First, Middle, Las	st)	Oertine	Date Of L	Jeani	2. Date of De		04	3. Time of Death
	Physicia /Medic		MAR CAN	CET E.	JAK	200		OCTOB	ER 8,	200 [°] 4ª°	1:24 P M
	Examin		4a. Facility Name (If not institution, give	e street and number)			Location of Deat	h		unty of Death	
			8213 PULASKI HWY 5. Social Security Number 6. S	ex . 7. Age (In yrs.		ROSEDA	If Under 24 Hrs	8. Date of Bi	rth	LT IMOR	place (State or Foreign
	Funeral Director			OM 3 F 4		nths Days	Hours Min.	MARCE	y Year) 19	57 Cou	nity ()
	pug 🗼		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location			7 1 1 1 1 1	,		10d. Inside City Limits
	Maryla fied a	to	MD. WOK	2620121 /2	OKNOW						1 Yes 2 □ No
	h the	irec	10e. Street and Number			f. Zip Code			10g. Citizen	of What Cou	ntry?
	ath will	ralD	UNKNOWA	<u>υ</u>			بالعام		0	.5.	A.
	ter de Items	by Funeral Director	11. Marital Status 1XNever Married 2☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No	.S. 13. Was E	Decedent of Hi specify Cuba	ispanic Origin? (S n, Mexican, Puerl	pecify Yes or No to Rican, etc.)	D- 14. I	Race - Ameri Black, White,	
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Ical ExInternual be natified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 2 No	Specify:		Spe	ecity: W	HITE
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest gra			of work done o	during most of wo	rking	16b. Kind o	of Business/Ir	ndustry
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d 2	al Hygid d other event,	Be Co	17. Father's Name (First, Middle, Last)	<u></u>			18. Mother's Nar	пе (First, Middle			
ylaı	should be ind Mental marked c	ToE	1-RADCIS	PUSH			MAKY	MAK	CAFE	TC	AM PBELL
Maryland	C/ cg - 20		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	dress Street a	and Number of Ru	ural Route Numb	er, City or To	wn, State, Zij	Code)
	s 1 and Health tem 27 other t		20a. Method of Disposition	20b. F	Place of Disposition	(Name of	INGIO	Date	20c. Location	on Lity or T	own, State
E O	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specification)	Hemoval from State	cemetery, cjematory	or other place	1. 10	12-04	BAL	TD.	UD.
Baltimore,	permit. Page Department o Importent: If any injury or once.		21. Signature Vaneral Service Licer	Shall and	22 Nan	e and Addres	ss of Facility	2829	HUD	500	37:
			23a. Part1. Enter the disease, or com shock, or heart failure. Ust only	plications that caused the deat	h. Do not enter the	mode of dyin	g, such as cardiad	or respiratory a	irrest,	3219	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		TESTINAL	11	WHAGE				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
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	ocuted nd transit	Examiner	Cause (Disease or Injury that initiated events	c							
60,	ficate be executed physician and s the burial-transIt		resulting in death) Last	Due to (or as a conseq	uence of):						
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Вох	death certi e attending d for use a	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		pic pregnancy				Date of delive	•
	that the death certifed by the attending detached for use a	Physician/M	in the past 12 months? 1 □Yes 2 □No 9 █Unknown	4☐Pregnant at time of d 9☐Unknown		er (specify)				Month	Day Year
P.0.	res that th igned by be detacl	/ Ph	Part II. Other significant conditions of	contributing to death but not res	ulting in the underly	ring cause give	en in Part I.	23e. Did	tobacco use c	contribute to t	he cause of death?
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of	<u>₽</u> = <u>P</u>	n: To	1 XYes 2 No 27. Manper of Death	28a. Date of Injury	28b. Time of	28c. Injury Work	4 □ Nursing F	lome 5 Res			SCENE
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident Investigation		Injury M		<br Yes 2 □No				
Division	al or Atter after de I Directo d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, fa	actory, office		28f. Location (City or To	Street and Nu wn, State)	imber or Rura	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysicien: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occu tion and/or investig	irred at the tim ation, in my or	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and date and place	manner as s	stated. the cause(s)
1	To th Withir To th comp	Me	29b. Signature and title of certifier	MA		29c. License	number C M E			gned (Month, ER 9,	
,	ĺn		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)						
	Sta	to.	- 1 -	fu, M.D. 32. Registrar's Signa	ature		nn Stree	et, Balt	imore,	Maryl	and 21201
*	Registr	-	OCT 1 4 2004	Benera	& kn	2 /2/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2004 Physician October 12, 12:20pm M Genofefa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Potomac Valley Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 23 1925 Birthplace (State or Foreign Country)
 NY 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □XF 79 067-18-6777 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ent of Health and Mental Hygiene.
sinst if item 27 is marked other than "natural; or items 23a or 28a-f show any or other transatic event, the Medical Extrainer mast tenrollined at any or other transatic event, the Medical Extrainer mast tenrollined at Sykesville 1X Yes 2 □ No Md Carrol1 Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21784 USA 4 Bethway Drive apt 2 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) deli clerk grocery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stanislaw Andrewzeska Zophia Hilinska 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 321 East Patrick St., Frederick, MD 21701 Linda Marie Duvall (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Srv. 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Sykesville, MD All County Cremation 10/13/04 * 4 □ Donation 5 □ Other (Specify) TATGHT FUNERAL HOME & CHAPEL, PA (Box195) Sykesville, MD 21784 (410)-795-1400 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOPULMONARY ARREST Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enail Janjing Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð ATRIAL FIBRILLATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes XNo 1□ Yes 2 No Division of Vital Hospital or Attanding Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA ၉ 1 ☐ Yes 2X No After this funeral c 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 5 Pending investigation 1 X Natural 1□Yes 2□No 24 hours after death. 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0061959 10/ 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

AMAN SIBAL.

OCT 1 4 2004

31. Date filed (Month, Day, Year)

LAMBERTON

DR

1299

32. Registrar's Signature

MD 20902

SILVER SPRING

				For State Registrar	State of Marylar		rtment of H			ene		32542
		Physici /Medic		1. Decedent's Name (First, Middle, ELLA CANN	ON JACKSOI	N			2. Date of Death Month	Day	Year 2004	3. Time of Death 2374 M
,·	<i>></i>	Examin Funeral	er	4a. Facility Name (If not institution, Second Security Number 6	. Sex 7. Age (In yrs.	. last birthday)		Location of Death MORE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	4c. County	N/.4	ace (State or Foreign
		Director		Usual Residence of Decedent 10a. State 10b. County	1 □ M 2 SQCF 10c. Ci	ity, Town or Lo		TIOUS WIII.	0303	1910		d. Inside City Limits
	:	ith the Marylan or 28a-f show is notified at	Director	MD N/			MORE 10f. Zip Code		10g	. Citizen of \	A	•
	ဖွ	filed within 72 hours after death with the Maryland Hygiene, Hygiene, or Items 23a or 28a-f show ther then "naturel", or Items 23a or 28a-f show ent, it e Medical Examiner must be notified at	Funerai Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 1 Yes 2000	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Rac Blac	S, A	ın Indian,
	15-0036	in 72 hours in "naturel", o	Completed by	3 Widowed 4 □ Divorced 15. Decedent's (Specify only highest	grade completed)	16a. Deced (Give life. L	OO NOT use retired,	during most of workii l)	ng	Specify b. Kind of Bo	usiness/Indu	ustry
`	and 2121	s 1 and 2 should be filed within 72 in the thanth and Mental Hygiene. Item 27 Is marked other then "natu other traumatic svent, Ita Medical	Be	Elementary/Secondary (0-12) 10+10 Gracie 17. Father's Name (First, Middle, La	College (1-40r 5+) N/A (St) C. CANNON	A	SSEMBI	18. Mother's Name		iden Suman	10)	ELECTRI
		and 2 should salth and Me n 27 Is mark er traumatic	To	19a. Informant's Name/Relationship	(Type, Print)			and Number or Rura	l Route Number, C	city or Town,	State, Zip (Code) CLMDZ104
7	Baltimore,	t. Page rtment o rtant: If rjury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Special Service Lies)	□Removal from State	ULAN	PY VALLE	eY 10.1	8.04 7	c. Location -	116	MD
	Ba	permi Depa Impo any ic		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused the dea			ss of Facility . GREEN (IMDRE N g, such as cardiac o				Approximate Interval Between
	7	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Coronas Due to (or as a coped		ny diss	ease				Onset and Death
		cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consect	quaries of).						
	68760,	icate be executed physician and s the burial-transit	dical	resulting in death) Last	Due to (or as a consect	quence of):						
	P.O. Box (To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attend foath. To the Funerel Director: Attenthis certificate has been signed by the attending physician and contested birector. Attenthis certificate has been signed by the attending physician and contested filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 27 No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of delivery	y Day Year
	rds, P.	w requires that the base signed by should be detact		Part II. Other significant condition	s contributing to death but not re-	sulting in the ur	derlying cause give	en in Part I.	23e. Did tobac	2 No		e cause of death?
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	of Vita	ding Physician	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of eatt 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	Othe	at 2	(Check only one) ne 5 Residence 8d. Describe how			
/	Division	o the Hospital or Attending Phinting Phymitin 24 hours attendeath. o the Funerel Director: After the completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	tion t be 290 Place of Injury - At h		M 1 🗆 Y	Yes 2 □ No	8f. Location (Stree City or Town, S		er or Rural i	Route Number,
		To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	edical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of my kn caminer: On the basis of examin- and manner stated.	owledge, death ation and/or inv	occurred at the tim estigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and ma and place,	inner as stat and due to t	ted. the cause(s)
	•		Σ	29b. Signature and title of certifier A Thus	mp imp		29c. License	0170	29d.	CO O	9/20	ay, Year)
		() Sta	te	30. Name and address of person when the second of the seco	10 completed cause of death (Ite	andal	South	,		208		

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #8 PER ANA BD G836 tifts #19 POAD SALA Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Richard 1022 October 8 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore University of Maryland Medical Center Bultimore 8. Date of Birth 2-01-1942 inhiplace (State of Foreign (Month, Day, Year)

Jan 2, 1942 Maryland Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1⊠M 2□F 62 233-68-1469 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State MD 10b. County 10d. Inside City Limits r than "neturel", or items 23s or 28e-f show the Modical Examinar must be notified at Baltimore 1 Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 Old Eastern Avenue 21221 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene. and the than "neturel", or lies marked other than "neturel", or lies ury or other traumatic event, Its M. of Call Ex. nilling ury or other traumatic event, Its M. of Call Ex. nilling ury or other traumatic event, Its M. of Call Ex. nilling ury or other traumatic event, Its M. of Call Ex. nilling ury or other traumatic event, Its M. of Call Ex. nilling ury or other traumatic event, Its M. of Call Ex. nilling ury or other traumatic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementany/Secondary (0-12) College (1-4or 5+) painter home improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jones ပ Margaret Wigger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Duncan/sister 840 Olive Branch Court Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or QDCB. ' 4 X Donation 5 ☐ Othe (Specify) 21. Si man et of Euneral et vice License na le S 22. Name and Address of Facility State Anatomy Baltimore, MD rector Board 655 W. Baltimore Street Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 8 montus Cancer -UN9 disease or condition resulting in death) /Medical Due to (a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine equires that the death certificate be executed burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death for in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy performed 1 Yes 2 No 34b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Division of Vital I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending М 1 Tyes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title certifier AU4176435 KISZO9 October, 8, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Jth Greene Street Bultimore MD 21201 La Department of Anosthesia 31. Date filed (Month, Day, Year) 32 Registrar's Signature State oaks OCT 1 4 2004 Registrar

Patrich Known as Charles Johnson

1 - For State Registrar

			1. Decedent's Name	(First, Middle, L	ast)							2. Date of De				3. Time of	Death
	Physicia		Charles	Johnson								Month Dec	Day	900	ear	0455	AM
	/Medic Examin		4a. Facility Name (/			ber)		4	tb. City, Town, o	r Locatio		0 10 0 01		County of		100	
	LAGITHIT	Ŭ.	Sino	i Hos	A. 1.40	Balto	200		BaH:	an i	e Cul	tu					
	Funeral		5. Social Security N	umber 6.	Sex 7	. Age (In yrs.	last birth		If Under 1 Year Months Days	If Und	er 24 Hrs. s Min.	8. Date of Birt	h v Year)	9	. Birthp	place (State o	r Foreign 1nk
	Director		214-26-4	946	1 <u>M</u> M 2□F	74	Y	rs.	violitia Days	riour	S IVIIII.	Month, Da May 28	, 193	30		<i>""</i>	IIIK
-	5		Usual Residence of			10- 01	Teller		*1							04 1-14- 01	
	show	ايا	10a. State MD	10b. County		10c. CII	y, Town Roll	or Loca timo								0d. Inside Ci 1 ∑ Yes	-
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	er de	nue	11. Marital Status		12. Was Deced	08S?	.s. unk	13. Wa	as Decedent of H (es, specify Cuba	lispanic an, Mexi	Origin? (Sp can, Puerto	ecity Yes or No Rican, etc.)	- 1	4. Hace - Black,		can Indian, etc.	
00	be filed within 72 hours after death with the Maryland half Hygiene. All distributions are not seen as a consecutive of other then "natural," or items 23a or 28e-f show event, it a Madical Examinant instituted at a confiner at	by F	1 Never Marri	ied 2□ Married	1 □ Yes If Yes, Give Year or Da	_	unk	1 🗆	Yes 2∏ No	Spec	ify:		5	Specify:		white	
500	hour tural		3 - 441004160	15. Decedent's			16a	Deceder	nt's Usual Occup	ation		unk	16b Kin	d of Busir	ness/In	dustry	unk
ה ה	in 72	ompieted		ify only highest g	rade completed)			(Give kir	nd of work done	during IT	ost of work	ing GIIK		u o. 220			unk
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yiand	lid be lental ked o ic eve	To B															
	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic ev	-	19a. Informant's N	ame/Relationship	(Type, Print)		19b.	Mailing	Address (Street	and Nur	nber or Run	al Route Numbe	er, City or	Town, Sta	ate, Zip	Code)	
Ë			Sinai Ho	ospital			2	2401	W. Belv	vede	re Av	enue Ba	1 t i m c	re M	D 2	1215	
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2	ages ant of it: If i		1 🗆 Burial 2	Cremation 3	□Removal from S cify) in/sta	tate	semetery	/, сг е та	tory or other plac	C O)	i I	i					
Бант	artme artme ortan injur							22.1	Vame and Addre	ss of Fa	cility						
ğ	permit. Pages 1 and Department of Health Important: If item 27 any injury or other t once.		21. Si in tare of E	onald S	Mary D	irecto	r	Sta	ite Anat timore,	omv	Board 2120	l 655 W.	Bal	timo	re S	Street	
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			Immediate Cause		y one cause on ea	ch line.		i		1	_					Onset and I	ween Death
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	be executed ician and burial-transit	Exa	that initiated events resulting in death)	Last	c. Due to (d	or as a consec	quence o	f):							=	-	
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X Q Q	andin use	N/N	IF FEMALE: 23b. Was deceder	t pregnant	23c. If yes, outo	ome of pregn	ancy	3□⊑	ctopic pregnancy				23	3d. Date o		-	
מ	death e atte id for	icia	in the past 12 1 ☐ Yes 2 I		4 ☐ Pregna	int at time of o			Other (specify)	у			1	Month	1	Day 1	r'ear
5	v requires that the de been signed by the should be detached	Physici	9 🗆 Unknown		9□ Unkno	wn											
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ecords,	quire an sig uld b		Hyper	tersion	1							1 🗆 '	Yes 2□]No 3	☐ Prob	ably 4 🗹	Jnknown
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0	ndin tth. r: Aft	atio	1 √ Natural 2 □ Accident	5 Pending investigat		i, Day rear)	""	ilain		Yes 2	□No						
DIVISION	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	288. Place			m, stree	t, factory, office			28f. Location (: City or Tox	Street and	Number	or Rura	al Route Num	ber,
	afte afte	Certification:	4 - Homicide		buildin	g, etc. (Speci	iy)				1	Only or Tol	wii, State)				
	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director. After this certific completely filled in by the funeral director,		29a. Certifier		Physician: To the												
	n 24 n 24 ne Fu	edical	(Check only one)	2 Medical Ex	aminer: On the ba and mann	er stated.	ation and	vor inve	stigation, in my c	pinion, «	Jeath occur	red at the time,	date and	piace, and	a due t	o the cause(s	
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier	0 0 1				29c. Licens	se numb	ər		29d. Date	signed (Month,	Day, Year)	
			B	Land	Mas,	N	de		KE	So	000		John	معد	4	200	4
			30. Name and add	ress of person wh	o completed cause	of death (Ite	m 23a) (Type, Pr	rint)							,	
			Eduer	d Kadi	Im ust		rai	Ho	spoter	20	Ball	inone					
	Sta		31. Date filed (Mor	nth, Day, Year)	/ h	egistrar's Sign	ature		1								
	Regist	rar	00	T1 4 200	14 50	wa	19	_/	pour	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 Year 2004 Physician 8:1019 M F._ October HOWARD KOHNE /Medical 4a. Facility Name (If not institution, give streat and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner かった Armde Anne Arma If Under 1 Year | If Under 24 Hrs. 7. Age (In yr. last birthday, 5. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1 M 2 □ F Director 213-34-6546 Nov.20.1938 Maryland Usual Residence of Decedent death with the Maryland works 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f shov The Madical Exactive must be notified at 1 Yes 2 No Director Maryland Anne Arundel Pasadena 10e, Street and Number 10a. Citizen of What Country? 10f. Zip Code 7742 Glen Avenue United States 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Kaydon Corp. iges 1 and 2 should be filed voil of Health and Mental Hygies It Item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard F. Kohne Martha Kacala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Kohne (Wife) 7742 Glen Avenue, Pasadena, Maryland 21122 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ò permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10-14-04 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 art1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) cance Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 25 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 unpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day 27. Manner of Death 28d. Describe how injury occurred Certification: Diractor; After 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Records, of Vital vision

Baltimore, Maryland 21215-0036

within 24 hours a

State

Year)

4 Homicide

31. Date filed (Month, Day, QCT

29a. Certifier

Medical

* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

(Check only one) 29b. Signature and title of certifie

30, Name and address of terson who completed cause of death (Item 23a) (Type, Print) KVE 130195

V 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SIMMS-**Physician** DETOBEL /Medical 4c. County of Death
BATIMOKE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DUSON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Hours Days Months 1 □ M 2 🕏 60 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County Town or Location 7 is marked other then "netural", or items 236 or 286-1 show treumetic event, the Madical Examinar must be notified at MD SALTI MORE 1 Yes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number DUN ROMING 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (D)No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Criban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. becify: DLACK filed within 72 hours after 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DONOT use retired)

SERETARY 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r College (1-4or 5+) 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) Be HEATHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or To Department of Health a Importent: If item 27 Is any Injury or other tree HIGHTER 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cometery, crematory or other 20c. Location - City or Town, State .15.04 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BACTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER pears OVAVIAN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit attending physician and Box 68760 Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Hospice 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel E 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)25205 tober 11, 200 x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles Street Towson, Md. 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2004 Registrar 0CT 1

Jimms-King

			1 - For State Registrar	State of Maryland		ent of Health and ate of Death	Mental Hygier	2001	3951.7
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last 4e. Facility Name (If not institution, give	Willian	-	19er Cey	2. Date of Death Month Cober	Day Yeer	4 9: 40PM
	Funeral Director		5. Social Security Number 6. Se	V	last birthday) If Und Yrs. Month	der 1 Year If Under 24 H	rs. 8. Date of Birth in. (Month, Dey, Yee	00=	rthplace (State or Foreign Country) aryland
	72 hours after deeth with the Maryland naturel; or Items 23a or 28a-f show disal Examinat he putified at	ral Director	10a. State 10b. County Maryland Baltimor 10e. Street and Number 1111 Wiseburg Road	re		Zip Code 21161		Citizen of What C	
9000	hours after de ural', or Items il Examinar n	d by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Amed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes	cedent of Hispanic Origin? Decify Cuban, Mexican, Pui 2 X No Specify:			ite, etc. White
21215-0036	within iene.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		life. DO NOT	work done during most of w	vorking	Kind of Business Power To	,
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be (17. Father's Name (First, Middle, Last) Emert Alfa 19a. Informant's Name/Relationship (T)	Keys	19b. Mailing Addre	18. Mother's N Bess ss (Street and Number or I	ame (First, Middle, Meide sie Ca	en Sumame) therine	Milstred
	and 2 lealth a m 27 is		Bessie Alverta Bur 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ F	rris/Sister Removal from State	7316 Gollace of Disposition (A	den Fern Ct.	Elkridge.		nd 21075
Baltimore,	permit. Pages 1 Department of H Important: If Ita any injury or ot onca.		21. S maturo F nera Service Lior hs Bryan W. Clary	ard	22. Name	Cemetery 10 and Address of Facility on Funeral H Padonia Ro		oenix, M ney Vall	
8	Physician /Medical Examiner		23a. Part 1. Expert h disease, or complished, or hear failure. List only of Immediate Commercial Final disease or condition resulting in death)	icati ns that aused the death. ne cluse on each line. a. Due to (or as a consequence)	e M.e. n	ode of dying, such as cardi	ac or respiratory arrest,	.,	Approximate Interval Between Onset and Death
8760,	te be executed ysicien and te burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Chase (Disease or Multy	Due to (or as a consequence. Due to (or as a consequence)	<u>-</u>				
P.O. Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 ☐ Ectopic			23d. Date of del Month	livery Day Year
	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions con	tributing to death but not result	Iting in the underlying	cause given in Part I,	23e. Did tobacco		o the cause of death?
Vital Records,	The ate h page	e Completed	25. Was case referred to medical	ion '		00 Plus 4 P	24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
of	은 판매	ToB	examiner?		ER/Outpatient 3 C 28b. Time of Injury	Other	Home 5 Residence 28d. Describe how inju		cify)
Division	pital or Atteurs after de are Directo	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify))		28f. Location (Street a City or Town, Stat	'e)	
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1	ner: On the best of my knowner: On the basis of examination and manner stated.	on and/or investigation	d at the time, date and place in, in my opinion, death occurred. License number	curred at the time, date an	s) and manner as nd place, and due ate signed (Month	to the cause(s)
)	6+1		30. Name and address of person who co	impleted cause of death (Item	23a) (Type, Print)	0553	71 Oet	oker 10	2,2004
*	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	tvenut	- Dart	innore 1	viaryl	mu 2127/

			rieds						d Mental Hy	_	·.
		•	for State Registrar		,		tificate of		•	Reg. No.	32548
	Physicia	an	1. Decedent's Name (First, Middle,	Last)					2. Date of De	_	3. Time of Death
	/Medic Examin	al	Soon Ok Kim 4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, o	r Location of C	Death	4c. County of	Death
	LXamin	C1	Stella Maris @ M	ercy			Baltimo			n/a	
	Funeral Director			. Sex 1 ☐ M 2 ☐ ¥	7. Age (In yrs. la	a <i>st birthday)</i> Yrs.	Months Days		Min. (Month, Da	y, Year)	Birthplace (State or Foreign Country) South Korea
	D.		213-92-5617 Usual Residence of Decedent		100 Cibi	Tournelle			эсрт.	20 1347 2	
	Maryla f show	ō	MD Baltimo	ro	Tue. City	Baltin					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	n the l	lrect	10e. Street and Number	ле		Daitiii	10f. Zip Code			10g. Citizen of Wha	
	s 23a o	ral	12 Strabane Ct.	10.140.0-	day Francis III	C 10	212		2 (Coopily Van er Ne	Kore	American Indian,
36	be filed within 72 hours after death with the Maryland hal Hygiene. ad other than "natural", or Items 23a or 28a-f show event, the Madral Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Marrie 3 □ Widowed 4 □ Divorced	Armed Fo	2 XNo		was Decedent of F If Yes, specify Cub		? (Specify Yes or No Juerto Rican, etc.)	Black, Specify:	White, etc. Korean
21215-0036	72 hou	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup kind of work done	during most of	working	16b. Kind of Busin	ness/Industry
121	within ene. than "	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire Busines	- /	er	Retail	Service
	e filed al Hygi I other vent, L	Be Co	17. Father's Name (First, Middle, La			Sindi	. Dusine.		Name (First, Middle,		20.7.00
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mannatic event.	To	Young Tae Min	- Circa Dulath		10h Maili	a Address /Street		on Kim	ar City or Town Str	oto Zin Codol
			19a. Informant's Name/Relationshi Sung Neung Kir		nd		•		altimore,	-	116, ZIP COO6)
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or othar tra once.		20a. Method of Disposition		20b. P	lace of Dispo	esition (Name of matory or other pla		/15/04	20c. Location - Cit	ty or Town, State
ţi	permit. Pages Department of I Important: If ite any injury or of once.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Furrial Service)		Du	20	Nome and Addre	on of Engility			m, MD 21093
Bal	permit. Pa Departmer Important any injury once.		Bryan W. C	ary		10	Lemmon W. Pad	Funera onia Ro	l Home of d., Timon	Dulaney ium, MD	Valley, Inc. 21093
			23a. Part1. Enter the disease, or c shock, or head failure. List o Immediate Cases (Final	omplications that on the one cause on the	each line.					rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Due to	(or as a consequ	PARU Ance of):	en 716	(11	Le .		
	*	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	uence of):					
	te be executed ysician and te burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Oissace or injury that initiated events resulting in death) Last	C	/						
760,	sician a burial	cal Ex	rosumy in county case	Due to	(or as a consequ	ience oi):					
89	2 > 4		ISCENIAL C	0.							
). Box	The law requires that the death certificate be ex tte has been signed by the attending physician page 2 should be detached for use as the burial	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live I	tcome of pregna birth 2 Petal nant at time of de lown	déath 3[Ectopic pregnanc Other (specify)	у		23d. Date o Month	*
P.0	that the	y Phy	Part II. Other significant condition	s contributing to d	leath but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?
rds	equires en sigr buld be	ed by							11	Yes 2 No 3	□ Probably 4 □Unknown
Records,	aician: The law re certificate has be irector, page 2 shu	Completed							24a. Was autopento	osy pric	re autopsy findings available or to completion of cause of the cause o
Vital	Phyaician: this certifica	Be	25. Was case referred to medical examiner?	Hospital:			Ott		Death (Check only		
of	Phy this ral d	J: To	1 Yes 2 No 27. Manner of Death	1	of Injury oth, Day Year)	28b. Time o			ng Home 5 Resi	dence 6 🗹 Other . how injury occurred	
ion	Attending r death. actor: After by the fune	atlo	1 ØNatural 5 ☐ Pending 2 ☐ Accident investiga	ation	ith, Day Year)	Injury		Yes 2 No			
Division	al or Att	Sertiflo	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Plat	e of Injury - At ho ling, etc. (Specif)	ome, farm, st	reet, factory, office		28f. Location (City or To		or Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:		xaminer: On the b					place, and due to the occurred at the time,		
	To the Tro the Company	Σ	29b. Signature and title of certifier	A				se number		29d. Date signed (Month, Day, Year)
	1		30. Name and address of person v	no completed cau	se of death (Item	1 23a) (Tvne		0854		10/1	4/2009
_	Q		David Ri	selverg	3015	STA	OU PL	Balt	imore m	rd. 212	02
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 4 20		Registrar's Signa	ture	Sparks	,			

04-06536 Tommy Koehler RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene.

			1 - For Stete Registrer	otate of ivia			tificate of		Mental Hygi		
	۰	4.	Decedent's Name (First, Middle, Last)				unoute of	Doutin	2. Date of Death	g. No. 200	3. Time of Death
	Physici /Medic			Tommy	I	Koel	nler		October	Day 2004	
	Examin		4a. Facility Name (If not institution, give stre	et and number)			4b. City, Town, o	r Location of Death		4c. County of D	
			South Bound 95 @ 9	5/ 495 S	plit		Beltsv	ille		Prince	Georges
	Funeral Director		5. Social Security Number 220-15-7859 Usual Residence of Decedent	2□F 7. Age	(In yrs. last birt	rhday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) NOV • 5,1		Birthplace (State or Foreign Country) [aryland
	/land		10a. State 10b. County		10c. City, Town	or Loc	ation				10d. Inside City Limits
	Mary 1-1 sh	to	Maryland Baltimo	re				Middle R	iver		1 ☐ Yes 21 No
	th the	Director	10e. Street and Number				10f. Zip Code			g. Citizen of What	Country?
	23a		1205 Reames Road					21220		United S	tates
36	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28e-f show the Madical Evanal per mult be invilled at	by Funeral	11. Marital Status 12. 12. Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent E Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	0	1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 ★No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Al Black, W Specify:	
Maryland 21215-0036	72 hou natura dical E	ted	15. Decedent's Educat	on	16a	Deced	ent's Usual Occup	ation	16	Sb. Kind of Busine	White
215	within 73 ene. than "n	Completed	(Specify only highest grade c Elementary/Secondary (0-12)	ompleted) College (1-4or 5-		(Give I life. D	rind of work done of NOT use retired	during most of world)	king	o. rand of busines	33 modelly
21	filed wit Hygiene other tha	Con		Years		Se	curity G	uard		Securit	У
pu	d d d	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
Ya	should bents and Ments amarked	To	Michael B. Koehle						rlene Ken		
Mar	2 a s a		19a. Informant's Name/Relationship (Type, Mr. Michael Koehl						ral Route Number, C ddle Rive:		
	s 1 and of Health item 27 other tr		20a. Method of Disposition	CI/I a circ			ition (Name of			c. Location - City	
Baltimore,	t. Partmer rtant rjury		1 🖾 Burial 2 □ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	oval from State	cemeter	y, crem Y V	atory or other place alley Me	m. Gdns.	10/13/20	04 Timo	nium, MD
Ba	permi Depa Impo any ir		21. Signature of Funeral Service Licensee			79	22 Wise .	Ave. Dur	Home of Dandalk, Man	cyland 2	Inc. 21222
	₹		23a Part1. Enter the disease or complicate shock, or heart failure. List only one of	ons that caused ause on each line	the death. Do n a.	ot ente	r the mode of dyin	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MULTIP			RIES				Onset and Death
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.O. Box	that the death cer	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome o 1□Live birth 2 4□Pregnant at t 9□Unknown	Fetal death		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
<u>α</u>	res that igned b be deta	by Pr	Part II. Other significant conditions contrib	uting to death but	not resulting in	the und	derlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ecords,	The law requires that the ate has been signed by the page 2 should be detached.	eted b							:	2 /2 No 3□F	Probably 4 □Unknown
$\mathbf{\alpha}$		Completed							24a. Was an autopsy performed	d? prior to	autopsy findings available completion of cause of second 2 No
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ital:			3 DOA Othe		h (Check only one)		(
of		H	25.7163 2 NO	8a. Date of Injury	28b. Ti		3 DOA 28c. Injury	4 Nuising no	me 5 Residence 28d. Describe how		ecify) (scene)
Division	th. : After s funer	tlor	1 □ Natural 5 □ Pending 2 ★Accident investigation	(Month, Day)	Year) In	jury O A	Work	? es 2KNo	DRIVER OF	CAR WU	BLUED IN
Visi	or Attendation director: in by the	ifica	3 Suicide 6 Could not be	8e. Place of Injur	y - At home, fare	-			28f. Location (Stree	t and Number or F	Rural Route Number,
	s after all Dir	Certification:	4 - Horriciae	building, etc.	(Specify)				Sib 95 e 40	itate)	
		edical (29a. Certifier 1 Certifying Physici (Check only one) Medicel Exeminer:	n: To the best of On the basis of e and manner state	examination and	death o	occurred at the time estigation, in my op	e date and place	and due to the caus	a(s) and manners	o state d
	To the within To the comp	Me	29b. Signature and title of certifier				29c. License O.C.M	number		Date signed (Mor	
}) West							tober 10,	
	5+1		30. Name and address of person who comp AMA RWS (eted cause of dea	ath (Item 23a) (T	ype, P	nint) 111 Pe	nn Stree	t, Baltimo	ore, Mary	yland 21201
:	Star Registra		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar		D.	back				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 430PM october Jean Kadninski 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital Contex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 19,1917 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TF 166-16-7408 87 Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Items 23e or 28e-f ahow iner rest be notified at 1 Yes 2 XNo Md. Baltimore Reisterstown Direct 10g. Citizen of What Country? 10f Zio Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 44 Hanover Road 21136 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status other traumatic ayant, the Medical Examiner in ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Food Stores Cashier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Philip K. Kubera Anna Bohen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph L. Kachinski, Jr. - Son 12609 Ivy Mill Rd., Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. Oct. 16,2004 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21117 22. Name and Address of Facility 21. Signature of Funeral Service L Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metabolic Agdosis /Medical Due to (or as a consequence of): Examiner Hyperkalemia Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of): Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed SCHEDOVA that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Cther (specify) P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Junknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 🗌 Yes 1 Yes 2 No 2 🕱 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide Hospital 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 100 MO 00000507 October 12,200x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 old court Road Randalls town, Manyland 21133 Maryjoy Majia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State QCT 1 4 2004

Registrar

			State of Maryland / Dep	partment of Health and M	-	_	
		•	FOI	ertificate of Death		. No.? () () ()	22551
	Physicia	20	Decedent's Name (First, Middle, Last)		2. Date of Death Month #	Day Year	3. Time of Death
	/Medic		Bernard W. Koontz Sr.		act	10 200	4 2:42AM
	Examin	er	North Arundel Hospital North Arundel Hospital	4b. City, Town, or Location of Death Glen Burnie		4c. County of Deat Anne +	Frundel
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday				hplace (State or Foreign untry)
	Director		213-34-7118 ^{1⊠M 2□F} 67 Yrs.	Months Days Hours Will.	8. Date of Birth (Month, Day, Y Feb. 08	1937	MD
and	A ==		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I.	_ocation			10d. Inside City Limits
Mary	in sh	tor	Maryland Anne Arundel	Pasadena			1 ☐ Yes 2 ☐ No
th the	or 28a	Direc	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?
ath w	s 23a	Funeral Director	7702 Suitt Drive	21122	-if . V - a - N -	USA 14. Race - Ame	sissa tadisa
ter de	tem fratr	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ XNo	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
OCO.	Exa.	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: Wh	nite
2 P	natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of worki. DO NOT use retired)	na	b. Kind of Business	
A Ida	than	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	Operator		Anne Aru	ublic Works ndel Co.
all a Z Z Z J J J J J J J J J J J J J J J J	ist lygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be multiped at	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		
aryida should b	marked matic ev	To	Melvin Koontz	Mary	G. Kan		
~	th and 7 la m traum			O Cuitt Doing Door		-	Zip Code)
16, 1	item 27 other tr		20a. Method of Disposition 20b. Place of Disposition	2 Suitt Drive, Pase cosition (Name of ematory or other place)	Pale 20	c. Location - City or	Town, State
Pages	nent of ant: If i			Hill Cemetery 200		altimore,	Maryland
baitimore	Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.			22. Name and Address of Facility			Home, P.A.
	TOPEO		23a. Part. Enter the disease, ir complications that caused the disease. Do not en	3111 Mountain Road,			22 Approximate
	hysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final		^		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to for as a consequence of:	10 1 L	Cance ance		5 months
E	xaminer		Sequentially list conditions, b. Advanced	Prostate Co	ma		
1ad	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
oU,	ysician and he burial-transit	Еха	that initiated events c. Due to (or as a consequence of):				
- 9	hysicia the bu	dicai	d				
X OX	ed by the attending ph detached for use as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	iven
ا الله الله الله الله الله الله الله ال	atten d for u	Physician/M	in the past 12 months? 1 Vec 2 No	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
ָב בַּ	by the	hys	9 ☐ Unknown				
ords, P.O.	ng ed	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	\/	the cause of death?
ecords		etec			24a. Was an	/ >	Itopsy findings available
r	certificate has b	ompieted			autopsy performe	prior to a	completion of cause of
	artiflica ctor, p	BeC	25. Was case referred to medical examiner?		(Check only one)	12 163	9410
OT VITA	this la	မ	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient			ce 6 □Other (Spec	cify)
		tion	27. Manner of Seat 28a. Date of Injury (Month, Day Year) 28b. Time Injury 2 Accident Investigation		28d. Describe how	injury occurred	
VISI	ector: by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 4 ☐ Homicide 5 ☐ Could not be building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
NIU S	ra Dir						
Hoen	within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation in my opinion, death occurre	ed at the time, date	and place and due	to the cause(s)
To the	Mithin Comple	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Mont	h, Day, Year)
-	+		Adeynka O, hanjem	= D59728	(oct 10	, 2004
	1	1	and manner stated. 29b. Signature and title of certifier Adeywise Or Langer 30. Name and address of person who completed cause of death (Item 23a) (Type Adey in Ka O, Laiyemo, MD, No. 31. Date filed (Manth Day, Year) (32. Registrar's Signature)	3. Prign) Acus Dal Hi	ospita 0	(10- P.	nia mi ni-ce
	Sta	ate	31. Date filed Meants, Day, Year A. (32. Registrar's Signature	The France 110	Je in the	Gren Bur	nie, 1111021061
	Registi		UCI 1 4 2004	goods			

To the tospital	4 hours unerel	Medical Ce	29a. Certifier (Check only 2 Medical Examine) 29b. Signature and title of eartifier	cian: To the best of my know r: On the basis of examination and manner stated.	vledge, death occ on and/or investi	gation, in my op	nion, death occur	red at the time, date a	s) and manner as not place, and due rate signed (Month	to the cause(s) Day, Year)
JIVISION OT VITAL	4 hours after death. "unerel Director: After this certificate has lely filled in by the funeral director, page 2.	Certification; To E	27. Manner ol Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	spital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify)	28b. Time of Injury		4 Nursing Ho	28d. Describe how inj 28l. Location (Street a City or Town, Sta	ury occurred and Number or Ru	
Ital nec	rtificate has b	Be Completed	25 Was case referred to medical examiner?				26. Place of Deal	24a. Was an autopsy performed? 1 Yes 2 N	prior to death?	opsy findings available ompletion of cause of
necords, r	been signed by the should be detached	ρ	Part II. Other significant conditions contributed by Carlotte Carl	•	Iting in the underl	ying cause give	n in Part I.	1 🗆 Yes	2 No 3 Pro	
The law requires that the death certified	by the attending pheached for use as the	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	b. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3□Ecto ath 5□Oth	opic pregnancy er <i>(specify)</i>			23d. Date of deli Month	very Day Year
8 / 50, ate be executed		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or as a consequence of	· ·					
/	nysician Medical xaminer		23a. Fart1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. cause on each line.	Des	e mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
barriit. Pages 1 ar	Depirtment of Importent: If i any njury or one		14 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	ST.	1111	me and Address		E JOHNSON		
	Health ar tem 27 is other trau		19a. Informant's Name/Relationship (Type CAROLYN YORI 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Rer	DAUGHTER 20b. Pla		ITON PLE	CASURE RI			1619
Maryland 21 1d 2 should be filed wi	ital Hygi od other svent, I	To Be Co	10TH GRADE 17. Father's Name (First, Middle, Last) FRANK ANDRYCHOWSKI	-	HOMEM		18. Mother's Nam EVA SLA	e (First, Middle, Maide	N HOME en Sumame)	
IZIS-UUSD rithln 72 hours af	ne. han "natural", e Modical Ex	Completed by	3 A Widowed 4 □ Divorced 15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Year or Dates: tion completed) College (1-4or 5+)	16a. Decedent's (Give kind life. DO N		iring most of work		Kind of Business/	
so after death v	or Itams 23a	y Funeral Director	1 Never Married 2 Married	E ROAD . Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 [X] No If Yes, Give	If Yes	21619 Decedent of His s, specify Cubar res 2 No	panic Origin? (Sp., Mexican, Puerto		JSA 14. Race - Ame Black, White Specify WHIT	e, etc.
. I Z I S-UUSO within 72 hours after death with the Maryland	ral', or itams 23a or 28a-f show Examinar nust be nailfied at	Director	MD QUEEN ANNE		ESTER	Of. Zip Code		10g. C	itizen of What Co	1 ☐ Yes 2 ☐ No
	Funeral Director			1 2 □xF 88	Yrs. Mo	onths Days	Hours Min.	8. Date of Birth (Month, Day, Yea 6/01/1916		place (State or Foreign untry) YLAND 10d. Inside City Limits
	Examin	7	4a. Facility Name (If not institution, give structure SPA CREEK CENTER 5. Social Security Number 6. Sex	eet and number) 7. Age (In yrs. la		ANNAPOL	Location of Death IS If Under 24 Hrs.	Į.	C. County of Deat	DEL
	Physicia /Medic		CLARA HELEN KRAWO					OCTOBER 7,	2004	4:45 A. M

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar			-		Cer	tificate d	of D	eath			Reg.	No.		2755
		1. Decedent's Name (First, Mi	ddie, Lasi	1)								2. Date of I		Day	Year	3. Time of
cian Iical	_	CATHER	NE_	M. K	IMBLE							10	/		2004	9,40
iner		4a. Facility Name (If not institu			mber)			4b. City, Tow			Death				y of Death RFORD	CO
		163 W DEEN 5. Social Security Number	AVEN 6. Se		7. Age (In v	rs last hirt	thday)	ABER		If Under 24	Hrs.	8. Date of E	Birth			place (State or
il F		569-32-0335		_M 2 ∑ F	,,,,ge ()		Yrs.	Months Da	ays	Hours	Min.	(Month, APR.	Day, Ye		Cour	RGIA
		Usual Residence of Decedent														0d. Inside Cit
_		10a. State 10b. Cou	nty		100.	City, Towr	n or Loc	ation							'	1 Tyes
Director		MARYLAND HA	RFOF	RD CO		A]	BERI	DEEN 10f. Zip Coo	de				10a.	Citizen of	What Cour	ntry?
																,
Funerai	2	163 W. DEEI	1 AVE	12. Was Dec	edent Ever in	ı U.S.	13. V	∠⊿ /as Decedent Yes, specify (LOO1		n? (Sp	ecify Yes or	No-		ice - Americ	
		1 Never Married 2 N	1arried	Armed Fo	2 X M 00			Yes, specify (Puerto	Hican, etc.)			ack, White,	etc.
ò		3XXWidowed 4 □ Divor	bec	If Yes, Gi Year or D	Dates:			L 105 201	MAO	эрвину.				Speci	BLA	CK
etec	בוכו	15. Dece (Specify only hig	ient's Ed hest grad	ucation de completed)		16a.	(Giva I	ent's Usual Oci and of work di OO NOT use re	lone du		of work	ing	16b	. Kind of I	Bu <i>s</i> iness/In	dustry
Completed	2	Elementary/Secondary (0-1 12th grade	2)	College (1-4or 5+)			TARY S		ISE				N/A		
au au	ע	17. Father's Name (First, Midd	ile, Last)								s Name	e (First, Midd	lle, Maid		m <i>e)</i>	
ToB		unknown								Ruby	Mai	nn				
-		19a. Informant's Name/Relati	onship (7	ype, Print)		19b	. Mailin	g Address (St	treet an	d Number	or Rur	al Route Nun	ber, Ci	ity or Town	n, State, Zip	Code)
		Shirley A. Da	vis/∏	aughte				Cameror	n St	.Blv	d.,	Alexa	ndr:	ia Va		
		One Marked of Direction														
		20a. Method of Disposition		Removal from	- 1	b. Place of cemeter	Dispos ry, crem	sition (Name of natory or other	of r place)			Date	200	. Location	- City or To	own, State
		XXBurial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	on 3 🗆		State	cemeter	ry, crem D Ml	atory or other EMORIAI	r place) L	1		Date 5-04			•	RYLAND
DCB.		XXBurial 2 Cremati	on 3 🗆		State H.Z	cemeter	ny, crem D Ml 22 WM	EMORIAI Name and A C BROV	<i>r place)</i> L Address WN (of Facility	0-10 NIT	6-04 Y FUNE	ABI RAL	ERDEE HOME	SN, MA S-HARF	RYLAND
ODCe.		XXBurial 2 Cremati 4 Donation 5 Othe 21. Signature Pure of Services	on 3 r (Specify	Koll	State H.	cemeter ARFOR	D Ml	EMORIAI Name and A C BROV 21 S PE	rplace) L Address WN (HILP	of Facility COMMUI	0-10 NIT HIA	6-04 Y FUNE BLVD.	ABI RAL , Al	ERDEE HOME BERDE	SN, MA S-HARF	RYLAND ORD, P D 2100
OUCE.		XXBurial 2 Cremati 4 Donation 5 Othe 21. Signature Provided Sandaria Sandar	on 3 r (Specify	Moll plications that	State H.F.	ARFOR	D MI 22 WM 33	EMORIAI Name and A C BROV 21 S PI or the mode of	r place) L Iddress WN (HIL7 f dying,	of Facility COMMU ADELP such as co	0-10 NIT HIA	6-04 Y FUNE BLVD.	ABI RAL , Al	ERDEE HOME BERDE	SN, MA S-HARF	RYLAND
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Physician/Medical Examiner	Physician/medical Examiner	A Burial 2 □ Cremati 4 □ Donation 5 □ Othe 21. Signature □ Pure 1 23a. Part □ Enter Under 1 23a. Part □ Enter Under 1 23a. Part □ Enter Under 1 23a. Part □ Enter Under 1 23a. Part □ Enter Under 1 23a. Part □ Enter Under 1 23a. Part □ Enter Under 1 25a. Enter	on 3 _ r (Specify of Specify of Comp.	Due to C. Due to 23c. If yes, ou 1 Live 4 Preg 9 Unkr	caused the deach line. (or as a control	sequence sequence sequence sequence sequence resulting in	y, crem Mil 22 WM 3: not enter of):	EMORIAI Name and A C BROW 21 S PI ar the mode of	r place) L Iddress WN (HILF f dying,	of Facility COMMU ADELP such as co	0-10 NIT HIA ardiac	FUNE BLVD. or respiratory	ABI RAL , Al arrest,	HOME BERDE	EN, MA C-HARF EEN, M eate of deliver	RYLAND ORD, P ID 2100 Approximate Interval Betwoest and C
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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month Day, Year)

30. Name and address of person who completed cause of death (liem 23a) (Type, Print)
615, S. Union Ave, Havre de Grace, MD, 21078 32. Registrar's Signature

29c. License number

D 4 3 / 15

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Year Physician VIRGINIA KENLY <u>4:48</u> a ^M MARGARET OCTOBER 2004 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HAVRE DE GRACE HARFORD CO CT 112 BLUEBILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2XXF 74 MARCH 3 1930 MARYLAND Director 218-30-6093 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-1 show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director HAVRE DE GRACE MARYLAND HARFORD CO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23s 112 BLUEBILL CT 21078 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced "neturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. d 2 should be filed within 7 in and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASST. PERRY POINT VA HOSP. 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY E. CEVIS JOHN CEVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treun 112 Bluebill Ct., Havre de Grace, Md, 21078 Nadine Kenly/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) HARFORD MEMORIAL 10-15-04 ABERDEEN, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P
321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death KNOBNO VISIUM Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner nentension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner that the death certificate be executed burial-tran and a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) _ detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No P 1 Yes 2 ER/Outpatient 3 DOA this hours after death.

unerel Director: After this y filled in by the funeral di 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Hospitel or Attending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 319 ς 31. Date filed (Mol th, Day, Year) B sist ar's Signature State

Registrar

1 4 2004

			For (5	State of Maryland	/ Depa	artment of H	lealth an	nd Mental Hy	giene		
		1	For State Registrar		Cei	tificate of l	Death		Reg. No.	AL.	39555
П	Physicia	an.	1. Decedent's Name (First, Middle, Last)	0.5.0711		1/ A T	7	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al -	HOWARD ta. Facility Name (If not institution, give stre	GARTH		KATZ 4b. City, Town, or		Octob	- 3	200 M	8.31AM
	Examin	er	SINAI H	OSPITAL		BAI	time			,	N/A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bi	rth	9. Birthpla	ace (State or Foreign
	Director		215-42-2381 1 X M	2UF 61	115.			DEC.23	,1942	<u> </u>	MD
	yland how		10a. State 10b. County		Town or Lo	cation				10	d. Inside City Limits
	8a-fs	cto		TIMORE		1	OWING	S MILLS	45. 000		1 ☐ Yes 2 🕅 No
	with the	급	10e. Street and Number 619 HAMMERSHIRE RO	۸D		10f. Zip Code	21117		10g. Citizen of	what Count	USA
	death	Funeral Director		Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H		n? (Specify Yes or No Puerto Rican, etc.)	o- 14. Ra	ice - America ack, White, e	an Indian,
စ္က	hours after death with the Maryland turet', or Items 23a or 28a-f show at Examiner must be notified at	y Fu	1 ☐ Never Married 2 💢 Married	1 X Yes 2 □ No AIR		1 □ Yes 21X No	Specify:	uerto ricari, etc./	Speci		WHITE
		ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educat	Year or Dates: FORC	16a. Dece	dent's Usual Occup	ation		16b. Kind of E	Business/Ind	
<u>5</u>	within 72 ene. then "na:	Completed	(Specify only highest grade of		life.	kind of work done of DO NOT use retired	during most o d)	f working			
7	filed wit Hygiene other the		Elementary/Secondary (0-12)		SALE	.S (10 Mothods	s Name (First, Middle	I NSUF		
yiand	d be findal H	Be c	17. Father's Name (First, Middle, Last) HENRY		KATZ		JEANE		i, Malueri Surria	1110)	GLASS
	s 1 and 2 should f Health and Men flem 27 is marke other treumatic	To	19a. Informant's Name/Relationship (Type	, Print)				or Rural Route Numb	er, City or Town	n, State, Zip	
, Mar	is 1 and 2 of Health a ltem 27 is other tre		NORMA KATZ / WIFE				IRE RO	AD - OWING			
ore Ore	n O L		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Ren	noval from State	netery, crei	sition (Name of natory or other place		Date	20c. Location		
Baltimore,			4 □Donation 5 □Other (Specify)21. Signature of Funeral Service Licensee	MD				0/12/2004 SOL LEVIN			ILLS, MD
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	10.30		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	cause on each line.			-		arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
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	scuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
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687	ificate g phys as the		d								
ŏ	death certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnand		Ectopic pregnancy	,			ate of deliver	ry Day Year
O. B	at the dea by the at stached fo	Physician/Med	1 Yes 2 No	4☐ Pregnant at time of dea 9☐ Unknown	ath 5[Other (specify)				O. C.	,
٠ <u>.</u>	The law requires that the death certifical ate has been signed by the attending phy bage 2 should be detached for use as the	by Ph	Part II. Other significant conditions contri	buting to death but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to the	e cause of death?
spic	w require: been sig should b	ted b	Hyperlipiden					1	Yes 2□No	3 ☐ Proba	ably 4 Unknown
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	hysiclen: The law nis certificate has b I director, page 2 s						1	1 ☐ Yes	ONIERS		2 No
Ĭ	Physiclen: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2000	spital: 1 ☐ Inpatient 25 E	R/Outpatie	nt 3 DOA Oth	05	of Death (Check only sing Home 5 ☐ Res		ther (Specify)
Division of Vital	<u> = </u>	1	27. Manner of D ath Natural 5 ☐ Pending		28b. Time o				how injury occu		
Sio	Attending or death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon	an form at		Yes 2 □ No		(Street and Num	ther or Rural	Route Number
Σ	Dir Dir	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	ie, rami, st	eet, factory, office			wn, State)	201 07 1 10101	riodio mamber,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the			cien: To the best of my know r: On the basis of examination							
	the H hin 24 the F mplete	Medical	ane)	and manner stated.		29c. Licens			29d. Date sign		
	5 1 × 5 0	_	29b. Signature and title of certifier	lousi es) n !	000		558	_		7,2004
	13		30. Name and address of person who com	pleted cause of death (Item:	23a) (Type,) -[·	, , (00 100	(10- 4	100
	`		Frenerick Bu	irke, IR, MO	240	1 w. Bel	veder	ze Ave [saltin	rose, m	21215
	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 4 200	32. Registrar's Signatu	A	Look	41				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician /Medical Examiner

1 - For State Registrar

Funeral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed use as the burial-transit the attending physician and Division of Vital Records, P.O. Box 68760, be detached been signed by has this certificate after death

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 2:26 P Khazanov 2004 evgeniy October 10 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Randallstown Northwest tospita Center BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT.10,1923 6. Se 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1₩ 2□ F Hours Yrs ŰKRAINE 212-43-8557 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 BEDFORD AVENUE #415 21208 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify. Specify: WHITE \$ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANICAL ENGINEER ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) KHAZANOV **YOSEF ESFIRA** (UNKNOWN) ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TATYANA KHAZANOVA / DAUGHTER 6806 CHEROKEE DRIVE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 10/12/2004 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Seprice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) . Multiple organ system & days Due to (or as a consequence of): failure Acute renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner 1 month schemic courdismy openth that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. fibrillation 2 No Hypertension 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes mellitus Chronic renal tailure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Hepatitis C disease // Systemic inflammatory response syndrom + 1 - Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 10, 2004 socion MD D28462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, Maryland 21133

Registrar

Boston

31. Date filed (Month Day)

Hospita

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year ED **Physician** WARD 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner D Bultimore TINKON 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1**X**M 2□F 216-68-5445 Director Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28a-f show treumatic event, it a Medical Examinar must be notified at 1 Yes 2 No Be Completed by Funeral Director IIMER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 305 2/2/5 or Items 23a 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces' 1 Never Married ☐Yes 2 No 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: BUACK 3 Widowed 4 Divorced "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Second (n/6-12) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r College (1-4or 5+) RIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE. BALTO ADRIENNE 05 Pages 1 and 2 CKJON item 27 i other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: if ite eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facil 21. Sanature & Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Imonths Meumenia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ussase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate 1 ☐ Yes 2 7 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ 1√10 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After f Certification: 5 Pending investigation 1 Matural 2 No 1 🗀 Yes death. 2 Accident Director; d in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide

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State Registrar

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within 24 hours a To the Funerel [

31. Date filed (Month, Day, Year) **SCT 1 4** 2004

4 Homicide

29b. Signature and title of certifier

29a Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mp 0

82. Registrar's Signatur

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav "Physician DORIS MAY LEIMBACH 2:00 PM 2004 Oct. 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Catonsville Baltimore Charlestown Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 91 Yrs 213-34-5284 Director Dec 6, 1912 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23a or 28e-1 show the Medical Examination must be notified at Baltimore Catonsville Maryland 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 715 Maiden Choice Lane #711 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or item any injury or other treumetic event, the Medical Examination. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify À 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hutzler's Dept. Store Salesperson 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Mills Clara Tucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George E. Leimbach, Jr. (Son) 12011 Tralee Rd., #203 Timonium, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 10/13/04 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. la 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician EMENTIA EARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fram, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day jo 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 Yes or Attending Physician: Be funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 TYes 2 □ No nin 24 hours after death.

the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) the 29d. Date signed (Month, Day, Year) Tot 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN OHOICE LW. 71) RIZETT TNO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Reperso 4 2004 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month James R. Lucas 2004 1:25 A^M October 6 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Towson **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) May 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Birthplace (State or Foreign
Country) 1 X M 2 □ F Director 76 Yrs. 328-20-1249 1928 Indiana Usual Residence of Decedent with the Maryland item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Modical Exampler is ust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 □ No Maryland N/ABaltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 East Lee Street #1102 21202 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within : nent of Health and Mental Hygiene. int: if item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Public_Relations Wine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown ဂ Mildred Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy M. Lucas / Wife 10 East Lee Street #1102 Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages of Pepartment of Pepartment of Pepartment: If ite any injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/13/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor ^{22, Name and Address of Facility} Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Mary Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUPSIS

Due to (or as a consequence of): irrelas /Medical Examiner Nostroc concer 1CV25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ₫ in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) be detached ☐Yes 2☐No 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy 2.2019 2.2019 certificate JAMES LUCAS
Division of Vital 1 Yes Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 ☐ Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA After this 27. Manner of Seath Certification; 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours at To the Funerel D Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DCTOPER 13 Zaux 8303 and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N Charles St. nus

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day, Year)

4 2004

32. Registrar's Signature

Towson, Md. 21204

				ease Type or P					d Mental Hy		gible.		
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	Examin	er	4a. Fecility Name (If not instit				4b. City, Town, o		eath		nty of Death /A		
	F	Č.	HARBOR H	6. Sex 7	TER . Age (In yrs. la	ast birthday)	BALTI M If Under 1 Year		rs. 8. Date of Bi			place (State or Fo	oreian
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	n 18e	Irec	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?	
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Maryland	1 and 2 sho Health and I tam 27 is ma other traums		19a. Informant's Name/Relate Mary Lee /	tionship <i>(Type, Print)</i> wife			ng Address <i>(Str</i> eet Patrick		Rural Route Numb			yland 212	225
	Heall tam 2		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Name of natory or other pla	-	Date	20c. Locatio			
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Baltimore,	permit. Pages. Department of h Importent: If ite any injury or of		21. Signature of Funeral Ser	vice Licensee - Frances	uch		2. Name and Addre		Gonce Fu way Ba			e, P.A. yland 21	.225
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Registrar

			For State Registrar	-	artment of Health and Me tificate of Death	ental Hygien	9001	32561
	Physici	an	1. Decedent's Name (First, Middle, Last) Hilda F. Ludwi	<u>a</u>	2		ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street Acardel He		4b. City, Town, or Location of Death	1549564	c. County of Death	undal
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 27 F 86 Yrs.	If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Year lug 28, 19	9. Birth	place (State or Foreign ntry) D
	Maryland f show	or	Usual Residence of Decedent 10a. State MD Anne Aruno	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a or 28a-	i Director	10e. Street and Number 1271 Rock Hill Road	<u> </u>	10f. Zip Code 21122	10g. C	itizen of What Cou	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any ritury or other traumatic evant, the Medical Evantical artifical at anong.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto Ri I ☐ Yes 2 XNo Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
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Mary	nd 2 sho lith and l 27 is me r traume		19a. Informant's Name/Relationship (Type) Mrs. Joan C. Smith		ng Address <i>(Street and Number or Rural :</i> Rock Hill Rd., Pasa			Code)
ore,	iges 1 and of Head		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem	ioval noin State	sition (Name of Da natory or other place)		Location - City or To	
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8760,	cate be executed physician and the burial-transit	icai Examiner	Sequentially list conditions, 1 any, Leading of Interesting Cause (Disease or injury that initiated events resulting in death) Last	Disa to (or as a consequence of):	ve lung dissoce			Ance
P.O. Box 68	death certiff e attending ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown]Ectopic pregnancy] Other (specify)		23d. Date of deliv Month	ery Day Year
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Il Records,	The ate h	Completed	hyportension			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
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	Hospita 4 hours Funaral ety filled	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my knowledge, death r: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the cause(d at the time, date a	s) and manner as s nd place, and due t	stated. o the cause(s)
)	To tha within 2.	Me	29b. Signature and the pt certifier	anda mo	29c. License number 0002483		tate signed (Month,	
	F pl		30. Name and address of person who comes	MD 305 (Juspite				
• =	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

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Registrar

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4 2004

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Corole

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

October 11, 2004

			For State Registrar	State of Man	yland / Depa		t of H	ealth a			ene	04	32563
	Physici		1. Decedent's Name (First, Middle, Last) FLORENCE		LEVENT					Date of Death Month OCTUSION	Day 12	Year 2004	3. Time of Death
13%	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location of			4c. Count		
			GOOD SAMARITAN HOS					BALTIN					N/A
	. Funeral Director		010 03 0000	M 2 X F 7. Age (/	n yrs. last birthday) 93 Yrs.	If Under Months	1 Year Days	If Under 2 Hours		Date of Birth (Month, Day, Y UNE II,	1911	9. Birthp Coun	lace (State or Foreign try) I L
	ow ow		Usuel Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation						1	0d. Inside City Limits
	8a-f sh	ector	MD N/A	1	BALT								1 X Yes 2 □ No
	3s. or 2	i Dire	10e. Street and Number 6998 MARSUE DRIVE	#1 - D		10f. Zip		21215		100	g. Citizen of	What Coun	USA
	death	ner		12. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Was Deced	ent of Hi	spanic Origi	in? (Specif	y Yes or No- can, etc.)		ce - Americ	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or tlems 23s or 28a-f show ta M. Jical Ext. iliter i ust be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 W Widowed 4 Divorced	1 □ Yes 2 🛣 No If Yes, Give Year or Dates:	F	1 ☐ Yes 2		Specify:			Speci		WHITE
15-("netu	lete	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	dent's Usua kind of wor DO NOT us	k done d	uring most	of working	16	Sb. Kind of E	Business/Ind	lustry
212	d withir giene. er than	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	SECRI						STATE	OF MA	RYLAND
Maryland	I be filed ntal Hygid ed other event, II	Be	17. Father's Name (First, Middle, Last)		WINE ²	TCVV		18. Mother	's Name (F	First, Middle, Ma	uiden Suma		1ENTZKY
Z	should nd Me mark mark	To	SAM 19a. Informant's Name/Relationship (Type)	ов, Print)			(Street a		or Rural F	Route Number, (City or Town		
	1 and 2 Health ar tem 27 is			SON				VE - 1		MORE, M			
Baltimore,	of in the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕍 R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, cren JEWISH W/	natory or of	ther place		Date 10/15		oc. Location		
alti	permit. Page Department of Importent: If any injury of once.		JEWISH WALDHEIM CEM. 10/15/2004 FOREST PARK, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., IN 8900 REISTERSTOWN ROAD - PIKESVILLE, MD								INC.		
	82589		Edward (Kunt								LE, N	
	Physician /Medical		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	NONIA	er the mode	e or aying	g, such as c	ardiac or r	espiratory arres	τ,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):								
,092	ate be executed hysician and the burial-transit	icai	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):								
.O. Box 68	that the death certifica ed by the attending ph detached for use as II	ompieted by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							ate of delive	ry Day Year		
o,	signed b	by PI	Part II. Other significant conditions con	9		, ,				V 4		tribute to th	e cause of death?
ord	w requires been sign should be	eted	ZHMENIC USSA	MUCTUE!	"ULMUNA	NT	Disi	203E		1X Yes			ably 4 Unknown
Il Records,	The lay ate has page 2	Comple								24a. Was an autopsy performe	d?	prior to con death?	osy findings available inpletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe		of Death (C	Check only one)			
of	Phys this ral dii	To	1 Yes 2 No	1 × Inpatient	2 ER/Outpatien		A	4 Nurs	-	5 Resident d. Describe how)
ion	Attending Ph r death. sctor: After th by the funeral	ation	Natural 5 Pending investigation	28a. Date of Injury (Month, Day Y	ea <i>r)</i> Injury	М	8c. Injury Work 1 🔲 Y	? ′es 2 □ N			,		
Division of	spitel or Attendi ours after death. terel Director: A filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)							et and Number or Rural Route Number, State)			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Phys	sicien: To the best of riner: On the basis of example and manner stated	amination and/or in	occurred a vestigation,	at the tim in my op	e, date and inion, death	place, and	d due to the caus at the time, date	se(s) and m e and place,	anner as stand due to	ated. the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier Mmmm A	m			License	number			Date signe		
	2		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type,	Print)	W	to No	ww				
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	,	100	1		sivo		+1239	1

	,	1 - For State Registrar	State of M	/arylan		artmen rtificate			and M		Reg. No.	004	32564	
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Las A LIMA Job 4a. Facility Name (If not institution, give	ice t	100n	٤			Location of			5/2004	Yea	6:20am	
Funeral Director			9x 7. A □ M 2 2 F	Age (In yrs. 75	last birthday) Yrs.	If Under Months		If Under:	24 Hrs.	8. Date of B Novembe	irth 25, 1	928 ^{9. E}	Frederick Sirthplace (State or Foreig Country) CK	
e Maryland ia-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Frederick 10c. City, Town or L					ocation Frederick						10d. Inside City Limit	
3a or 26	I Director	10e. Street and Number 7905 Old Seventh S	Street			10f. Zip Code 21702				10g. Citize	en of What (Country? SA		
72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Examinations to notified at	by Funeral	11. Marital Status 1 Never Married ZXMarried 3 Widowed 4 Divorced	Armed Forces 1 Never Married 2 Married 1 Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)		4. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. white	
within sene.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		r 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homewaker			ng	16b. Kind	d of Busines	os/Industry Own Home			
be file stal Hy id oth avant	To Be (17. Father's Name (First, Middle, Last) Waldon Bennett Hick				18. Mothe		(First, Middle Agnes Ha						
		19a. Informant's Name/Relationship (7 Frank Moore / Husk	• • • • • • • • • • • • • • • • • • • •	- 77			and Number or Rural Route Number of Street, Frederick M							
00		20a. Method of Disposition ↑□ Burial 2 □ Cremation 3 ↑ 4 □ Donation 5 □ Other (Specify)	e Elm	Place of Dispo emetery, crem rwood Ce	natory or of metery	her place	I	0/9	104	Wood	ward, (or Town, State	
permit. Pag Depertment Important: I any injury o	21 1	21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore MD 21230 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.												
Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each	tine. PTi L	Emileuence of):	er the mode	of dying	i, such as	cardiac o	r respiratory			Approximate Interval Between Onset and Death IODAYJ	
cate be executed physician and the burial-transit	Ical Examiner	cal Examiner	Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Two to (or a		uenca ct):	MIL	- I	TAC	DW:	ANE			8 WEEK
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/MedI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	Ideath 3 □	Ectopic pre					23	d. Date of d Month	elivery Day Year	
luires that n signed k	þ	\	ontributing to death but not resulting in the underlying cau			luse give	n in Part I.					to the cause of death? Probably 4 Unknow		
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ending Physician: aath. or: After this certific	Certification; To Be (25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 Inpai	jury Pay Year)	ER/Outpatien 28b. Time of Injury	28 M	Bc. Injury Work 1	4 Privir	rsing Hor	(Check only ne 5 Res	idence 6 [how injury o	occurred		
To the Hospital or Atti within 24 hours after de To the Funeral Diractic completely filled in by the		4 Homicide determined		etc." (Specify	<i>(</i>)					City or To	wn, State)		Rural Route Number,	
To the Hosp within 24 ho To the Func completely if	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	iner: On the basis	of examinat	wledge, death tion and/or inv	estigation,	in my op	inion, deat	f place, a h occurre	and due to the ad at the time,	date and pl	lace, and du	e to the cause(s)	
T with	2	29b. Signature and title of certifier	Uno				License	319	12			osigned (Mor	nth, Day, Year)	
V		30. Name and address of person who caused the modern and the moder					rius	, Fr	200	eni lu	mD	, 2	1702	
Sta Registra		31. Date filed (Month Day Year) 4	2004 32. Regi	rar's Signa	ture /	A	oou	2						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year DOROTHY MANION DELVINE 3:31 PM OCTOBER 2004 /Medical 12 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death BALTIMORECH HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Hours Year, 1 M 2 XF 218 12 6585 Yrs. 80 Director 16,1924 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 17 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at N/A Maryland Baltimore Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3705 - 3rd Street 21225 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Intel Once. Homemaker 6th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Mabee Ella Mae Haslup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3705 - 3rd Street Christine Rathell / Daughter Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 10/15/2004 Glen Burnie, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligen 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL INFARCTION disease or condition resulting in death) 4 DAXS /Medical Due to (or as a consequence of): Examiner 6 DAYC NEUMONIA Sequentially list conditions, I any least 51 in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of). Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No of Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Jo 1 ☐ Yes 2 ☑ 1 No 1° Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Division 1 Natural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bundle K INTERN RESOOI OCTOBER 12 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Name and address of person who completed cause of death (Item 23a) (Type, Print)
BINDU KANAPURU HARBOR HOSPITAL 3001 SOUTH HANOVER STREET, BALTIMORE
MARYLAND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 1 4 2004

			State	e of Marylai		nent of Health an cate of Death	d Mental Hyg	iene	0.1	
1. Decedent's Name (First, Middle, Last)										Time of Death
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			Coastal Hospic	1	the Lo	the Sa	lisbure	1 W) comi	
	Funeral Director		5. Social Security Number 3/5 - 14 - 6975 Usual Residence of Decedent	7. Age (In yrs.		Inder 1 Year If Under 24 Hours N	Ain. 8. Date of Birth Month, Day.	19/3	9. Birthplace Country) Marylat	(State or Foreign Nd
	filed within 72 hours after death with the Maryland hygiene. ther than "netural", or items 23a or 28a-f show int, the Medical Examiner must be notified at		10a. State 10b. County	10c. Ci	ity, Town or Location)			10d. Jr	nside City Limits
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	ith th	Funeral Director	10e. Street and Number		10	. Zip Code	10	g. Citizen of	What Country?	
	s 23a	a	3070 Union Church Road	1		21866			USA	
_	item item	Į.	Armed	Decedent Ever in U Forces?	J,S. 13. Was D If Yes,	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - American In	dian,
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	Hygier Hygier ther th	ပိ	8			Homemaker			Own Hom	ie
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ary	2 should the and Ment is marked aumatic e	၉	19a. Informant's Name/Relationship (Type, Print)		19h Mailing Add	Rona Co		O	O	
	C @ 60 60		Dwight W. Marshall (So	n)	P O BO	ress (Street and Number or x 665 - 3067	IInion Chus	on Don	, State, Zip Code	MD 21866
ore			20a. Method of Disposition	20b. P	Place of Disposition cemetery, crematory	(Name of			City or Town, S	
Ĕ	Pages ment of the ent: If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	om State		Cemetery	10/12/04	Tvler	ton, Ma	rvland
Baltimore,	permit. Pages 1 and Department of Health Importent: if item 27 any injury or other tu once.		21. Signature of Funeral Service Licensee	2 Pust	22. Nam	e and Address of Facility			con, na	Lytana
_			Mary Beth Bradshaw	-Pruitt	306	adshaw & Sons W. Main Str	oot - Cria	fiold	MD 210	17
			23a. Part1. Enter the disease, or complications the shock, of heart failure. List only one cause o	at caused the death n each line.	h. Do not enter the	mode of dying, such as card	iac or respiratory arres	it,	Appro	oximate val Between
Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in death) a. Cevelrovascular Accident								Onse	t and Death	
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æ	The law ate has page 2	ם							of death?	n of cause
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≥ :	Physician: r this certific ral director,	To Be	examiner?	√npatient 2□E	ER/Outpatient 3	Othor	eath (Check only one)			
0	ig Ph ter thi neral		27 Manner of Death 28a. Dat		28b. Time of Injury	28c. Injury at Work?	Home 5 Residence 28d. Describe how			
Sio	Attending or death. ector: After by the fune	catic	2 Accident investigation	July (Car)	M	1 ☐ Yes 2 ☐ No	2000 NOW Highly occurred			
<u>≥</u>	or Att after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place	ce of Injury - At hor ding, etc. (Specify)	me, farm, street, fact)	ory, office	28f. Location (Stree City or Town, S	t and Numbe	er or Rural Route	Number,
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	io una nospital or Atending Prysician: The li within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: On the	basis of examination	on and/or investigati	on, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and mar and place, a	nner as stated. nd due to the ca	use(s)
	Withi To th		29b. Signature and title of certifier	11	7	29c. License number	29d.	Date signed	(Month, Day, Ye	oar)
	1		1000 /		Mes	D2627	1	0-1	0-03	/
1	(h)		30. Name and address of person who completed car	use of death (Item :	23a) (Type, Print)	2 011	11 , /	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1150	
			31. Date filed (Month, Day, Year) 32	Registrar's Signatu	WX//3	3 Salish	MY) 01	802	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dayth Year **Physician** 200 OCTOBER MCNEAL 11 TELVIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDALLSTOWN BALTIMORE HOSPITAL NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 €F AL 057-26-5628 11.10.193 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County marked other than "natural", or items 23s or 28s-f show imatic event, the Marcical Examiner must be notified at CATONSVILLE MD 1 ☐ Yes 2 WNo BALTIMORE Funeral Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA N. ROLLING ROAD 122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Specify: BLACK 1 Tyes 2 NO Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SPRING GROVE UPATIONAL THER APIST 12th grade 2 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SELECTA MCKINNEY CHARLIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permil. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau. -296 DUBLIN DIZIVE GLEN BURNIE, MD 21040 J. WILLIAMS DEBORAH 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

■ Burial 2

□ Cremation 3

□ Removal from State 10.19.04 DWINES MILLS, MD GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAVEHN C. GREENE FUNERAL SERVICES
5151 BALTIMORE NAT'L PIKE BALTO MD 21229 21. Signature of Funeral Service Licentee Wargh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE CARDIOMYDPATHY **Physician** SEVERE /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed CARLIMOTAR CELL EMA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending М 1 Tes 2 No investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier media mo D0041410 OCTUBER 11 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 P MEHTA 21133. KANDALSTOWN MO 31. Date filed (Month, Day, Year)
OC 1 4 2004 14 15 817 ME

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

#32. Registrar's Signature

				Otate of Wil	•	Certificate of		, ,	leg. No.2 () (32568
	Dhoraini		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	0 -	Year	3. Time of Death
	Physici /Medio		Curtis Edgar Mu						1 30	04	10:05 P.M
>	Examin		4a. Facility Neme (If not institution, giv				4b. City, Town, or I		4c. County		
			11415 Lakeside		a the construct he at he had		Hagerstov			ngton	
	Funeral Director		5. Social Security Number 219-14-8412 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last birt 81	Months Days		8. Dete of Birth (Month, Day Feb 3,	1923	9. Birthpla Country Mary 1	ce (State or Foreign y) and
	filed within 72 hours efter death with the Marylend Hygiene. the than "natural," or Items 23a or 28a-f show ent, the Modral Expriment man be notified at	tor	10a. State 10b. County 10c. City, Town or Location							100	d. Inside City Limits 1 ☐ Yes 2√ No
	h the	rec	10e. Street end Number			10f. Zip Code			10g. Citizen of W	/hat Countr	y?
	th wit	alD	11415 Lakeside I	rive		2	21740		USA	A	
	ems ems	Je l	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of it If Yes, specify Cub	Hispenic Origin? (S	pecify Yes or No-	14. Race	- Americar	
Maryland 21215-0020	be filed within 72 hours efter death with the Marylen ital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Madreal Extrainer mant be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 A Yes 2 □ I If Yes, Give Year or Dates:	43 – 46	1 ☐ Yes 2X No		o i noun, oto.,		whit	
5-0	72 hc	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16e.	Decedent's Usual Occu (Give kind of work done	pation during most of wor	kina	16b. Kind of Bu	siness/Indu	stry
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22	filed withi Hygiene. rther than	ខ	17. Father's Name (First, Middle, Last	, ,		letter	carrier	ne (First, Middle,	US Pos		ice
and	ed all all all all all all all all all al	To Be	Lewis Henry Mull							-	
<u>Z</u>	d 2 should be th end Menta 7 is marked traumatic ev	۲	19a. Informant's Name/Relationship (19b.	Mailing Address (Stree		Marie T	_		Code)
S	47 5 6 7 5 6		Ellen Curtis/spor	•		1415 Lakesi					
Baltimore,	355		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif		20b. Place of	Disposition (Name of y, crematory or other pla		Date	20c. Locetion -		
Balti	permit. Peges 1 Department of H Important: If Ite any Injury or ott		21. Si Latur, of Euneral S ryice Licer ROD 21 d S	/ /	ctor	22. Name and Addre State Anat	omy Boar		Baltimo	ore St	reet
			23a. Pekil, Enter the diseese, or comshoot, or heart failure. List only	plications thet caused	the death. Do n	Baltimore,			est.		Approximate
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		AGE CH	RONIC DB				į,	Approximate interval Between Onset and Death
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68760,	tificate be executed g physician end es the buriel-trensit	edical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a c	onsequence of):					
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	s deel	SICI	Part II. Other significant conditions of	ontributing to death be	ut not resulting in	the underlying cause gi	ven in Part I.	23b. Did to	obacco use con	tribute to ti	he cause of death?
s, P.O.	es that the igned by t be detech	by Phy	TOLOSA - HUNT	JYNDRO	ME	MARNUTK	UTION	1/2 Y	es 2□ No	3 ☐ Proba	bly 4 ☐ Unknown
Division of Vital Records,	been s	Completed	ADRENAL MIS	UFFICEN	<u> </u>			24a. Was a perfor	in autopsy med?	eveil	e eutopsy findings able prior to pletion of cause ath?
æ	The law ate has page 2:	E	ALBESTOSIS					1 □ Y	es 2 No	1 🗆 1	Yes 2□ No
ita	iclen: The certificate rector, pag	Be	25. Wes case referred to medical examiner?				26. Place of Dea	ith (Check only or	78)		
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ion o	nding Pt ath. r: After th e funera		27. Manner of Death 1	28a. Dete of Inju (Month, Day		njury Wo	ryet irk?]Yes 2∐No	28d. Describe h	ow injury occurre	ed	
Divis	il or Atte effer de Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At home, far c. (Specify)	m, street, factory, office		28f. Location (S City or Town		er or Rural F	Route Number,
	To the Hospital or Attending Phys within 25 hours eiter death. To the Funeral Director: After this completely filled in by the funeral di	edical C	29a. Certifying Ph (Check only one) Certifying Ph	ysiclen: To the best on niner: On the basis of and manner sta	examination and	death occurred at the ti	me, date end plece opinion, death occu	, end due to the c rred at the time, d	ause(s) and mar ate and place, a	nner es stet nd due to th	ed. he cause(s)
	Within To the Comp	Me	29b. Signature and title of certifier	, 11/		29c. Licen:	se number	2	9d. Date signed		ıy, Year)
			Hand Tak	Broder	the	73	8892		10/1/0)4	
			30. Name and address of person who	completed cause of d	eath (Item 23e) (5 130		HVA1.	ER S	TOWN.
_			PAMELA FOX RAV	ASFORD, /	10 11	110 MESIC	AL CAM.	PUS RD	MD	21	10WN,
	Sta Registr	_	31. Date filed (Month, Day, Year) OCT 1 4 200	A -	ar's Signature	4					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 11, 2004 Year **Physician** Olive Ann Lykes Mattix 6:50P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 3, 1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖾 F 80 Yrs Director 192-16-7531 Argentina Usuat Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-1 show r than "natural", or Items 23a or 28e-f show the Wedical Examiner must be notified at 1 ☐ Yes 2X No Maryland Montgomery Directo Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7708 Masters Drive 20854 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. If Yes, Give Year or Dates: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other th eny Injury or other traumatic event, the QDCE. 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Norwood Lykes Olive Emrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 Beech Avenue #512 Baltimore, Maryland 21211 Paul R. Mattix, III / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State October 2004 13, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses ARIENT BENO MO1386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebrat von culan Physician /Medical Due to (or as a consequence of): **Examiner** stive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent premant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes Z No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 🗖 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 1 ☐ Yes 2 ☐ No 1□ Yes 2☑No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) RIZINO 1 Yes f Inpatient Medical Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sama M DOO 61596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Joanna Ku M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** October 1, 2004 6:00 PM M William Henry Morrison /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel 1730 Pleasantville Road If Under 24 Hrs. S. Date of Birth (Month, Day, Year)

Months Days Hours Min. Feb 8, 1940 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1X M 2□ F 64 204-28-7615 Yrs Pennsylvania Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Anne Arundel Glen Burnie Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number or items 23a 1730 Plesantville Road 21<u>061</u> USA by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item eny injury or other fraumatic event, the Mental and page. 1 ☐ Yes 2V No 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: If Yes, Give Year or Dates: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesperson automotive unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unk ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arthur Erhardt/friend 7975 Crain Hgwy #327 Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) 21. Signature of Funery Service Licenses de State Adatomy Board 655 W. Baltimore Street nar Baltimore, MD 21201 Part1. Enter the disease shock, or hear Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician teriose Due to (or as a consequence of) /Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequenna offi-Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 nknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 1 10 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1≱Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA inis 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 🗌 Homicide To the Hospital 29a Certifier Certifying Physician: To the best of my knowled a death occurred at the time, date and place, and due to the cause of and manner as stated Medical completely (Check only 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. eputy 29c. License numbe 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) ONES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar WCT 1 4 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2057 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 06:15 AM Pauline Marsh October 04 12004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 15, 19 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🂢 F Yrs. Director 219-28-5161 1931 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is markad other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examitar rust by notified at 1 √ Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2404 Pelham Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or Itams 23a any injury or other traumatic event, the Medical Experimentance. by Funeral 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 X Divorced white Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) registered nurse health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Roberts Fredonia Matthews ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Marsh/daughter 2404 Pelham Avenue Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State

`4 □ Donation 5 ₩ Other (Specify) in state Suna me of Euneral rice Licensee Ward 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cordionyopath Dilated disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Coronary ofter astery differe Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Fibrillation Hyperterion page 2 should Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 🗌 Yes 214No 1 TYes Hospital or Attending Physiclan: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred † Natural 5 Pending Injury after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L 29a. Certifier Medical 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2438946 LID October 04 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 LIPE

DCT 1 4 2004

31. Date filed (Month, Day, Year)

Union

32. Registrar's Signature

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Figure 19 Section of Death Action of Death	Pĥysician			Day Year
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The property of the property o			/	
Same Tool Free County		579-46-5468 1□M 2⊠F 68 Yrs.	Months Days Hours Min. Dec 15	Day, Year) 3, 1935 Maryland
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Physician Medical Examiner 23. April. Ener the disease of complications that caused the death. Do not not never the mode of drying, such as cardiac or respiratory arrest, procedure the mode of drying, such as cardiac or respiratory arrest, procedure that the cause of death of the caus	imor Pages nent of i	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Surial 2 ☐ Other (Specify)		
Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Physicia	Bait Bait Departit. Departit Importa	21. Signature of Funeral Savice Licensee Ronald S. Wante Director St	Name and Address of Facility Late Anatomy Board 655 W	. Baltimore Street
Physician Medical Examiner Image: Continue of the cause (Final decease or condition resulting in death)		23a, Hart1, Enter the disease, or complications that caused the death. Do not ent-		arrest, Approximate Interval Between
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Div safter al Dira ed in b	4 Homicide determined building, etc. (Specify)	City or 7	own, State)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	# Hospit 24 hour # Funari etely fille		n occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the within To the compl			29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD P. TRAVITZ MD 560 PIVERSIDE DR SALISBURY MD 21801		I full ful	036576	10/6/2004
,		30. Name and address of person who completed cause of death (Item 23a) (Type,	O PIVERSIDE DR S	ALIBBORY MD ZIBOI
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4. Apocks		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer 2 -44 25 10 10 **Physician** ERIC Mewman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE CIT MAKYLAND GENERAL MOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Bitthplece (State or Foreign 5. Social Security Number 6. Sex Days **Funeral** 10 M 20 F 214-08-0660 3 Yrs 6 and Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 PYes 2 □ No Completed by Funeral Director hmore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 1811 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within lealth and Mental Hygiene. om 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Be D. Newman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, Print) Important: if Item 27 is: eny injury or other traun W. Vine atrice cidar 1811 Baltimore. Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Ziv 10 21. Signature of Funeral Service Licens Carlton Address st. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebro ascular Accident
Brain Abcess. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Stage Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit see + ension The law requires that the death certificate be executed NERE Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. sician Completed by Physician/Medical phys. 88 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Minknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed page 2 No 1 Yes 2 200 certificate To the Hospital or Attending Physician: ector. 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 No 1 Inpatient 3 DOA 1 Yes 2 ER/Outpatient b this 28b. Time of 28a. Date of Injury (Month, Day Year, 28d. Describe how injury occurred Injury at Work? 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation in by the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide after within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 0/10/04 452 30. Name and address of person who completed cause of death (Item 23a) (Tipe, Print M. D. D) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 4 2004

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Mary, Theresa, Nea 0237 M October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2208 Annapolis Road Baltimore Cit If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 0CT 2, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F 220-10-1633 85 Yrs. Director 1919 West Virginia Usual Residence of Decedent 10a, State s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene.
Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, Ita M. Jical Examines must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2208 Annapolis Road 21230 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jacob Muia ပ Carmella Arggaio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is m any injury or other traum Maria Crush/Daughter 2208 Annapolis Road Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 10/14/04 Baltimore, MD 21. Signature of Funeral Service Leansee

Edward A. Gregorchik ²²Clame and Address of Facility of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician 4 days brainstem stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit and resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 6100d Pressure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1□ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 ▼No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29a, Certifier

29b. Signature

29c. License number P 18 58 [

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) October, 13, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street Baltimore, Maryland 21201-1595 Roberts

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar AMEND ITEM #	State of Maryla	•			, ,	ene g. No. A A L	32575
	Physicia	an	1. Decedent 3 Nation (1 1131, National, Eust)			L U/ 14/U4	JH	2. Date of Death Month October		3. Time of Death
	/Medic	al	Gerald Jos 4a. Facility Name (If not institution, give str	seph O'Kee	ere	4h City Town o	r Location of Death	L	4c. County of Dea	1:30 P M
1	Examin	er	7000 Kimmel Road	oot and number)		Mt. Ai			Freder	
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign puntry)
	Director		119-01-5218	92 92	Yrs.			ugust 27	, 1912 N	ew York
	yland		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	8a-f s	ctor	MD Frederick	Fı	rederick					1 √ Yes 2 □ No
	with the a or 2	Dire	10e. Street and Number			10f. Zip Code	_		g. Citizen of What Co	
	death ms 23	nera	2568 Bear Den Road	. Was Decedent Ever in	U.S. 13. \	Vas Decedent of H	<u> </u>	pecify Yes or No-	United St. 14. Race - Ame	erican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: WW]		1 ☐ Yes 2 HNo	Specify:	Hican, etc.)	Black, Whi Specify: W	nite nite
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pu	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, the Mag	BeC	17. Father's Name (First, Middle, Last)	- 			18. Mother's Nam	e (First, Middle, M	laiden Surname)	
yla	Ment Ment Marked Marked	卢	William J. O'Kee		+			le DeLos		
Maryland	d 2 sh th and th and ?7 is m traum		19a. Informant's Name/Relationship (Type Judith Lee O'Keefe						City or Town, State, MD. 2170	
	s 1 and Heal		20a. Method of Disposition		. Place of Dispo	sition (Name of natory or other place		eres i	Oc. Location - City or	
imo	Pages ment of ant: If i ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		nore-Was	shington	Crem 10/1		aurel, Ma	ryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 20059.		21. Signature of Funeral ServicerLicensee							Directors 21133-4784
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	tions that caused the de cause on each line.	ath. Do not ent	er the mode of dying	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Afher		rotic	Cardio	vascula	v Diseas	e Sylavs
	Examiner		f .	Due to (or as a cons	equence or).					
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	ntificat ng phy s as th	Medi	IF FEMALE:							
Вох	w requires that the death certificate be execul been signed by the attending physician and should be detached for use as the burial-trar	lan/I	23b. Was decedent pregnant in the past 12 months?	 If yes, outcome of preg 1 Live birth 2 □ Fe 4 □ Pregnant at time or 	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
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Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	spital:		oth		th (Check only one		ASSISTED
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sion	ending sath. or: Aft	atio	1 Natural 5 Pending investigation	(North), Day 10al)	Injury		Yes 2 □ No			
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	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edicai		r: On the best of my k r: On the basis of exami and manner stated.						
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	127		30. Name and address of person who com	4 5+	FY	Print) -eder	ict,	MD	217	03
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar's Sig	nature	lond	(

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryla		tificate o			eg. No.2	04	320	576
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and a	/Medi	cal	4a Fecility Name (If not institution, give s		Operie		4b. City. Town, or	Location of Deeth	4c. County		4:15	P.M.
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	Funeral Director		212 03 6311	7. Age (In yrs	s. lest birthdey) Yrs.	If Under 1 Ye Months Dey			^{Уеаг)} 5,1917	9. Birthpl Count Ma	lece (Stete o try) ry1ano	or Foreign d
П	lend		Usuel Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10	Od. Inside C	City Limits
	a-f sh	tor	Maryland Harford		Bel Air						1 ☐ Yes	2 🛛 No
	or 28	Funeral Director	10e. Street end Number			10f. Zip Code		10	0g. Citizen of 1		iry?	
	aeth v	erai	1318 Vanderbilt	2. Was Decedent Ever in	U.S. 13 V		.014	Specify Yes or No-	U.S	e - America	an Indian.	
Maryland 21215-0020	be liled within 72 hours efter death with the Marylend tiel Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 132 Yes 2 □ No If Yes, Give WW Year or Dates:		Yes, specify Ci	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	to Rican, etc.)	Bla	ck, White, e	etc.	
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Mai	200		19a. Informant's Name/Relationship (Type Rosalie Oberle	oe, Print) / wife			etend Number or Ri oilt Road		city or Town, r, Mar			Δ
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Baltimore,	permit. Peges Depertment of important: if it eny injury or once.		21. Signature of Funeral Service License) man all		Name and Add	dress of Facility Gonie Highw	once Funday Fal	eral Se			
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7	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	CHRONIC			LEUKE	EMIA			Onset and	Death
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E E		Com						1□Y9	8 3 No	10	Yes 2□	No
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o	Phys this ref di	n: To	27. Manner of Deeth	28a. Dete of Injury	28b. Time of	28c. In	jury et	fome 5 Reside			1	
ion	Attending or death. ector: After by the fune	atio	1 Naturel 5 Pending investigation	(Month, Dey Year)	Injury		∛ork? □ Yes 2 □ No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At l building, etc. (Spec	home, farm, stre ify)	eet, factory, offic	DB .	28f. Location (Str City or Town	eet a <i>nd Numb</i> , State)	er or Rural	Route Num	iber,
	Hospital or 24 hours efte Funeral Dir stely filled in	edicai	29a. Certifier (Check only one) 2 Medical Examina	clan: To the best of my kner: On the basis of exeminand menner stated.	owledge, deeth ation end/or inv	occurred et the estigation, in my	time, date end place y opinion, death occu	a, and due to the ca urred at the time, da	use(s) and ma te and place,	nner as sta	ited. the cause(s	s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and monner stated.		29c. Lice	nse number	29	d. Date signe	d (Month, D	ley, Year)	
	->-0		> / whelly	you MD		75	15344		10/101	2006	4	
	5X		30. Neme end address of person who com	npleted ceuse of death (Ite N1, 40, 62, 32. Registrar's Sign	m 23e) (Type, F	Print)			- 1101			
	2		SURESH DHANJX 31. Date filed (Month, Day, Year)	NI, MD, 622	S. UNI	ONAVE	HAVRE D	E GRACE	Mos	21078	>	
	Sta Begistr		OCT 1 1 2	and brener	mer &	1 An	20 1					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:45 AM Parrish October Catherine 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore Bultimore University of Margler If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number Z Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 70 Yrs. MARYLAND 212-30-5011 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2/ No ANNE ARUNDEL GLEN BURNIE Director 10g. Citizen of What Country? 10f Zin Code 10e Street and Number 207 PLYMOUTH LANE, APT C or items 23a 21061 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 **X X**o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 🖽 🔭 Baltimore, Maryland 21215-0036 3 Widowed XX Divorced neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of JAMES F. BUTTS CATHERINE A. GEOGHEGAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i 207 PLYMOUTH LANE APT C., GLEN BURNIE, MD 21061 VICTORIA PARRISH - DAGUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H importent: If ite eny injury or ot once. 1XXBurial 2 Cremation 3 Removal from State CEDAR HILL CEMETERY | 10/9/2004 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FINK FUNERAL HOME, P.A. - Funeral Service KELLYKGRESORY 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Enter the disease or heart failure 23a. Parti Immediate cause (Final West ncummonia Physician disease or condition resulting in death) /Medical Examiner Acute Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) signed by the a TYAS 2 THO P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No certificate 1 Yes 219 No To the Hospitel or Attending Physicien: 26 Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Ho 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 28b. Time of 27. Manner of Death after death. Certification: Injury 5 Pending 1 Avatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore Margland 22 South treence Wu)amel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 1 4 2984

State of Maryland / Department of Health and Mental Hygiene Registramend ITEM #19a PER INF C836 10/18/04 Jh Reg. No. 2. Date of Death 3. Time of Death Year **Physician** 10:15 A OCTOBER 12 2004 EDWARD Μ. PIASKOWSKI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1986 POPLAR RIDGE ROAD Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 10 M 2 F Yrs. 30,1921 Director May Maryland 219-01-2161 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ed other then "natural", or Items 23a or 28a-f shov event, the bladical Exercis at must be partitled at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1986 Poplar Ridge Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ② No (If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ON PIASKOWSKI Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then *na any injury or other traumatic event, It a Medic once. Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Butcher Esskay 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Piaskowski Bronislawa Alexander Jaskowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 Edward M. Piaskowski (Son) 1986 Poplar Ridge Road, Pasadena, Maryland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cem. 10-15-04 Baltimore, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee Tous 6 ann 23a art1. Enter the disease, or o'mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf 90517 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the P.0. detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ナルリハリカララロル 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 0170 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No ٥ this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending al or Attendin s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who, completed cause of death (Item 23a) (Type, Print) -C1

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2004

MARION

32 Registrar's Signature

			For	State of Man	-	epartment of I		lental Hy	giene		
			1 - State Registrar			Certificate of	Death		Reg. No.	Total Control	32579
	Physicia	an	Decedent's Name (First, Middle, Las					Date of De Month	Day	Yeer	3. Time of Death
	/Medic		MABEL	GRACI	E	PACHMAYR		OCTOBE		2004	5:35AM
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County		10
			NORTH ARUN] 5. Social Security Number 6. S		In yrs. last birti		BURNIE If Under 24 Hrs.	8. Date of Bir	Ann		ARUNDEL
	Funeral Director		1	2x 88		rs. Months Days	Hours Min.	(Month, Da	iy, Year)		place (State or Foreign ntry)
			217-26-4759A Usual Residence of Decedent	A 00				July	1,1916	New	v York
	yłanc		10a. State 10b. County	1	0c. City, Town	or Location				1	10d. Inside City Limits
	e-f s	ctor	Maryland Anne	Arundel	Pasa	dena					1 ☐ Yes 2 X No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a		7930 Shiple	y Road			21122		United	d St	ates
	e Las	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of I If Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Rad Blad	ce - Americ	can Indian, etc.
20	n 72 hours after deeth with the Maryland "natural", or Items 23a or 28e-1 show polical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No		1 □ Yes 2√2 No	Specify:		Specifi	Whi	to
2-003e	hour tural	ed t	15. Decedent's Ed	Year or Dates:	16a	Decedent's Usual Occu	nation		16b. Kind of B		
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7	within jiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Key Punch	Operator	^	Commer	cial	Credit
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<u>a</u>	aid be fenta rked ric ev	ToB	Frank C.	Benne	> ++		Marga	ret		Ci	llifin
a S	should ind Men marke umatic	_	19a. Informant's Name/Relationship (7			Mailing Address (Street			er, City or Town,		
Ξ	and 2 ealth a n 27 ic		Mrs. Helen Nei	sser (dau	ghter)	7930 Sł	ipley Ro	l. Pas	adena.	MD	21122
ore	iter off		20a. Method of Disposition	1	20b. Place of cemetery	Disposition (Name of r, crematory or other pla		ate	20c. Location -	City or To	own, State
E	Pages nent of ant: if it		1 ☐ Burial 2 【YCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	/) , , , , , ,	Bayvi	.ew Cremat	ory 10/16	6/04	Baltim	ore,	MD.
a	permit. Page Department of Importent: if any injury or once.		21. Signatury of Funeral Service Licen	VI 1/		22. Name and Addre	ess of Facility	. The] ***-		D 1
<u>מ</u>	20E 2 9	-	23a. Part1. Enter the disease, or compshock, or heart failure. List only	inich		3204 MOL	ess of Facility -Polyniak Intain Ro	C rune Pasa	raı но dena.М	me. D. 2	P.A. 1122
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	cations that caused the cause on each line.	e death. Do n	ot enter the mode of dy	ng, such as cardiac o	r respiratory a	rrest,	13	Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	CER	EBROI	/ASCULAR	AC0 186	CNIT			Onset and Death
	/Medical		resulting in death)	Due to (or as a c			,,, 50				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Examiner		Sequentially list conditions,		CATIO.		Allnow				
	p ti	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence o						
	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c		ATRIAL	FIBRIL	LATIO	N		
ק פ	ficate be executed g physician and is the burial-transit		l l		-	,					
08/P0	8 F =	edlcal		d							
_			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					· 23d. Da	te of delive	9rv
X Q Q	death a atter	iciar	in the past 12 months?	1□Live birth 2 [4□Pregnant at tim		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		ž .	onth	Day Year
	that the de ned by the a detached t	Physician/M	9 Unknown	9□ Unknown							
	es tha igned l be det	by P	Part II. Other significant conditions of		not resulting in	the underlying cause gr	ven in Part I.	23e. Did t	obacco use cont	ribute to th	he cause of death?
ğ	w require been sig should b	ed	HYPERTENSI	ON				10	Yes 2 □ No	3 🗋 Prob	ably 4 Unknown
Vital Records,	The law requires that the death cert the has been signed by the attending to a should be detached for use	Completed	CORONARY	ARTERY !	DISCAS	C		24a. Was	an 24b.	Were auto	psy findings available impletion of cause of
ř	sicien: The law s certificate has b lirector, page 2 s	mo.						perfo	rmed?	death?	
<u>=</u>	sien: artifica ctor.	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only o	•		
01	hysic this ce al dire	To	1 ☐ Yes 2 ☑ No			patient 3L DOA	ner: 4 ☐ Nursing Hor	me 5 🗌 Resi	dence 6 □Oth	er (Specif	ý)
	ding Pr h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. T	jury Wo		28d. Describe I	how injury occur	ed	
<u>s</u>	Attendi death. ctor: A y the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		441 6-		Yes 2 □No	204	C44		
DIVISION	or At after of Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	m, street, factory, office		City or To	wn, State)	er or mura	al Route Number,
	spitel ours sere! filled		29a. Certifier 1 Certifying Ph	ysician: To the best of r	nv knowledge.	death occurred at the ti	me, date and place, a	and due to the	cause(s) and ma	nner as s	tated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Examone)	niner: On the basis of ex and manner state	camination and	t/or investigation, in my	pinion, death occurre	ed at the time,	date and place,	and due to	the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier	LUI -		29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
			> Then you	hin Herry	CE 088	ICER D	0059185	-	OCTO	BER	12,2004
	9		30. Name and address of person who								
	7		OHMMAR KHIN,		TAC BI		EN BURN	SiE,	MD	2100	61
	Sta Registr		31. Date filed (Month Car, Year)	32. Registrar's	Signature	& Spar					
	ricgisti	41	- A		1	BOOLA	21				

Sparks

JOSEPH P PANTALEONE, JR Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State	of Manyla	nd / De	nartment	of He	aalth and	MA	ntal Hw	rione	

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F	Physici /Medic		1. Decedent's Name (First, Middle, Last, JOSEPH PAUL	PANTAL	EONE,	JR.					Date of Dea OCTOBE	ER 12,	2004	3. Time of Di 1:37	
	Examin		4a. Facility Name (If not institution, give 4405 MORNINGWOOD				4b. City,	Town, or L				4c. County MONTO	30MER	y co	
	Funeral Director			x XM 2□F	(In yrs. la	st birthday) Yrs.	If Under Months		Hours	Min. A	Date of Birth (Month, Day Pril 8	, Year 1945	9. Birthp New	Jersey	Foreign
	he Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	ery	10c. City,	Town or Lo	y			2-1-1-1				0d. Inside City 1 ☐ Yes 2	
	th with the 23a or 2		10e. Street and Number 4405 Morningwood	Drive			10f. Zip	Code 0832			•	United		•	
9036	hin 72 hours after death with the Maryland e. en "neturel", or Items 23a or 28a-f show Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates:			Was Deced f Yes, spec I ☐ Yes 2	**	anic Orig Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: Wh		
21215-0036	within ene. then "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+)	life. L	lent's Usua kind of wor DO NOT us nasin	k done dur e retired)	ring most	of working		16b. Kind of B	usiness/In	dustry	
Maryland 2	be file ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) Joseph Pantaleone						Mary	Senn	a	Maiden Suman			
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Maureen Pantaleon				-					r, City or Town, MD 20		Code)	
ore,		l š	20a. Method of Disposition 1 Darial 2 Tremation 3 DF	Removal from State	cei	ace of Dispo metery, cren	sition (Nam natory or o	ne of ther place)	1	Date		20c. Location		own, State	
Baltimore,	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Licens		Eas MO1		. Name an	d Address	of Facility	y Har	man Fu	4 Clift neral S Burnie	Servi	ce, P.A	
	Physician /Medical·		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each lin a. Due to (or as a	the death. e. tillul conseque	Do not ente	1	/	2000	cardiac or r		rest,		Approximate Interval Betwe Onset and De	en ath
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68760,	tificate b g physic as the b	ledical		d											
.O. Box	The law requires that the death certificate be executed to the seen signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at 9□Unknown	2 Fetal	death 3	Ectopic pro Other (sp						te of delive onth	ory Day Yea	ar
<u>α</u>	equires that I en signed by ould be detai	by	Part II, Other significant conditions co	ntributing to death bu	t not resul	ting in the ur	nderlying ca	ause given	in Part I.			bacco use cont	ribute to th	14	
Vital Records,		Completed									24a. Was a autops perform 120 Yes	sy	prior to cor death?	psy findings avantetion of cau	allable ise of
of	Physici r this cerral direc	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day)		R/Outpatien 28b. Time of Injury		A Other: 8c. Injury a Work?	4 🗆 Nui	rsing Home		ence 6 K⊈Oth ow injury occur		SCENE	
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hon . (Specify)	ne, farm, stre	eet, factory	, office		28f	Location (Si City or Town	treet and Numb n, State)	er or Rura	l Route Numbe	ìr,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C		sician: To the best on nar: On the basis of and manner sta	examination										
,	To the P within 2 To the F complete	W	29b. Signature and title of certifier Repulse 44	L'A m	W)		290	License n	oumber C M	ΙE	2	9d. Date signe OCTOBE			
11	l P		30. Name and address of person who co	ompleted cause of de	eath (Item	23а) (Туре,		1 Pen	n St	reet,	Balti	more, M	aryla	and 212	01
:	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registra	r's Signatu	Jre &	Soa	Ks/			-				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				OI Waryia	Certifi	icate of			Reg. No. [] []	1 0	12581
	Physic	an	1. Decedent's Name (First, Middle, Last)	Da	TERSO	1/		2. Date of Dea Month	Day Y	ear	3. Time of Death
	/Medi	cal	EVELYN 4a Fecility Name (If not institution, give street and		ILEKSU		4b. City, Town, or Lo	OCTOB		400	06:22 AM
	Examir	ier	HARBOR HOSPITI		ENTER		BALTI				
	Funeral		Social Security Number 6. Sex	7. Age (In yi	rs. last birthday) If	Under 1 Year onths Days		8. Date of Birti (Month, Da)	1.7		ace (State or Foreign
	Director		213-14-2100 1 M 2 DXF		83 Yrs.	oritris Days	Hours Mill.	Feb. 1		Counti	MD MD
	end we		Usual Residence of Decedent 10a. Stete 10b. County	10c. (City, Town or Locatio	าก				10	d. Inside City Limits
	Maryl -f ehc	ō	Maryland Anne Arunde				len Burnie	9			1 ☐ Yes 2 [X](No
	th with the Maryler 23s or 28e-f ehow	Director	10e. Street end Number		10	0f. Zip Code			10g. Citizen of Wh	at Count	ry?
	th wit	aiD	300 Washington Blvd.				21061		US	SA	
	tems ferms	Funeral	Armed	ecedent Ever in Forces?	U,S. 13. Was	Decedent of H s, specify Cub	lispenic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Black.	America White, e	
36	s afte	by F	1 Never Married 2 Married 1 Yes, 3 Widowed 4 Divorced Year of	s 2 💢 No Give r Detes:		res 2⊠ No			Specify:	Whit	te
Maryland 21215-0036	within 72 hours aftar death with the Marylend ene. than "natural", or items 23a or 28e-f ehow than "natural", or items 24 or 28e-f ehow he Madical Examiner must be notified at	8	15. Decedent's Education		16e. Decedent's	s Usual Occup	pation		16b. Kind of Busin	ness/Indu	ustry
215	thin 7. B. "n. Med	Be Completed	(Specify only highest grade complete Elementery/Secondary (0-12) College	d) e (1-4or 5+)	(Give kind life. DO N	of work done IOT use retired	during most of workir d)	ng			
21	ed wil	5	4		Horr	<u>nemaker</u>			House	ehol d	<u> </u>
and	be fill d oth	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Name				
Ĕ	d Mer	P	Frank Walters 19a. Informant's Name/Relationship (Type, Print)		10h Mailing Ad	drace (Street	Adelia and Number or Rura	M.		to Zin (Code
Σ	of trau		Mary Messoria (daugh	ter)			on Blvd.,				
Baltimore,	permit. Peges 1 and 2 should be filed within Depertment of Haalth and Mental Hygiene Important: If flem 27 is merked other than any injury or other traumatic event, the Mannes.	- 1	20a. Method of Disposition	20b	. Place of Disposition cemetery, cremator			Date 09	20c. Location - Cit		
Ë	Pege nent o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State	oly Cross		100		Baltimore	Ma Ma	arvland
alt	permit. Depertrimports any inju		21. Signature of Funer I Service Licensee	·	22. Nar	me and Addre					ome, P.A.
щ	20 5 2 3	1	And. Fr		31	11 Mou	ntain Road	d. Pasa	dena. MD	2112	22
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	Physician /Medical		Immediate Cause (Final	0.00	~						Onset and Death
	Examiner		disease or condition resulting in death) e.	Ehe	(>-					(06 days
		Jer			or as a consequence		umonio	ι.		1	6 Laur
	Attending Physician: The law requiras that tha death certificata be executed or deeth. sctor: After this cartificate has been signed by the attending physician end by the funeral director, page 2 should be detached for use es tha buriel-trensit	edical Examiner	Sequentially list conditions,	Due to	(or as e consequenc		1			-	o cuys
90,	ba exe cian e ouriel-	Ē	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	evere	. Deh	ydra	tion.			i i	6days
68760,	physic that	<u>Q</u>	that initiated events resulting in death) Last	Due to	(or as e consequence	e of):					
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oro	requii een s hould	eted	Deme Ntia					24a. Was e perfor	n autopsy 2 med?	4b. Were avail	e autopsy findings lable prior to pletion of cause
3ec	e law has b	ם								of de	eath?
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5	sician cartii	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 11	Inpatient 2	☐ ER/Outpatient 3[□ DOA Oth	26. Place of Death		ence 6 ⊟Other (Cassiful	
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io io	endin seth. or: Aff he fur	atio	2 Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M		Yes 2□No				
Division of Vital Records, P.O.	fred difference of the py the	Ĕ	3 ☐ Suicide 6 ☐ Could not be determined 28e. Ple	ce of Injury - At Iding, etc. (Spec	home, farm, street, facily)	actory, office	2	8f. Location (Si City or Town	reet and Number on, State)	r Rural I	Route Number,
	To the Hoepital or Attending Physician: The law within 24 hours after deeth. To the Funerel Director: After this carificate has completely filled in by the funeral director, page 2	edical Certification: To Be Completed by Physiclan/N	29a. Certifier 1 Certifying Physician: To t	ne heet of my kr	nowledge death occi	ured at the tin	no data and place of	nd due to the e	(a) and mann		
	Hoe Hoe Fun	dica	(Check only 2 Medical Examiner: On the	basis of examir anner stated.	nation end/or investig	ation, in my o	pinion, death occurre	d et the time, d	ate and place, and	due to the	ne cause(s)
	To the Hoepital or Attendi within 24 hours after deeth To the Funerel Director: A completely filled in by the f	Ž.	29b. Signature and title of certifier			29c. Licens		1	9d. Date signed (A	fonth, Da	ay, Year)
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 0.0 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 6:55PN Kagolio 11 0 2004 auline /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Baltimore niversity If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 3/11/1921 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 X X 83 TEXAS Yrs. 450-28-6885 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other then "netural", or items 23e or 28e-f shot treumatic event, the Medical Exam her must be notified at XMYes 2 □ No Director BALTIMORE CITY MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with 317 S. WOODYEAR STREET 21223 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ges 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 Is marked other then "netural", or Ite 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 4 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OWN HOME W.W. LYNCH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 317 S. WOODYEAR STREET, BALTIMORE, MD 21223 PETER RAGOLIO - HUSBAND other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ites 1 X Kurial 2 ☐ Cremation 3 ☐ Removal from State 10/14/2004 GLEN HAVEN GLEN BURNIE, MD ' 4 Donation 5 Other (Specify 21. Signature of Juneral Service Li 22. Name and Address of Facility FINK FUNERAL HOME- PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 GREGORY FINK #MOI148 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure—List only one cause on each line. Approximate Interval Between Onset and Death 23a Part , or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** in tarction days cerebra /Medical Due to (or as a consequence of): **Examiner** unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit hyperlipidemia Unknow Due to (or as a consequence of) attending physician Box 68760 certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy requires that the death Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>\$</u> Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 20 Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient Other: 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie neunlog residen 10 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) ireene MMS Baltmore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OC-tober Year Physician F. Roseborough 20021 Annie /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Stella Maris-Mercy If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 M 2√2 F 253-40-4237 Director 7-16-27 Ga Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits f show If item 27 is merked other then "natural", or items 23a or 28a-f show or other treumstic event, the Medical Examinar must be notified at 1 Yes 2 □ No NA Baltimore Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2604 Allendale Rd. 21216 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) RN Varies 12th grade yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fi f Health and Mental H item 27 is marked ot Maybell Johnson Beach Anderson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3018 Mayfield Ave., Baltimore, Md. Pages 1 and 2 nent of Health a ent: If item 27 is Chantae A. Rogers Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 10-20-04 Arbutus, Md. Arbutus Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, Md. Will 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cante /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-translt Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 07 discay Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has performed' 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6-Dother (Specify) NUSQUE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide

Records, P.O. Box 68760 Division of Vital

the Maryland

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ROSEBORAGE CHNICAMINATION CHNICAMINATION CHNICAMINA 21215-0036

Baltimore.

The law requires that the death certificate be executed To the Hospitel or Attending Physician: death. after death Director: / within 24 hours aft To the Funerel Di completely filled in

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Medical

29b. Signature and title of certifie

Rischera

4 Homicide

(Check only one)

31. Date filed (Month 5)

29a. Certifier

29c. License number 0854

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 2307 12/12/

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

md ZIZM

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

301 ST Paul
32 Aegistrar's Signature

-655 G	52		1- State of Maryland De 1- State of Maryland De 1- Registrar	part erti	tment of He ficate of L	ealth a	and Me	ntal Hy	giene Reg. No. ()		375	ΩI.
	Physicia	20	Decedent's Name (First, Middle, Last)					Date of De		Year	3. Time	of Death
	/Medic	al	Richard G. Russell, Sr.		b. City, Town, or			Octob	er 10.	2004	1:01	РМ
	Examin	er	4a. Facility Name (If not institution, give street and number) North Arundel Hospital		Glen Bu		or Death			unty of Death		
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	ay)	If Under 1 Year	If Under	24 Hrs. 8.	Date of Bir	th	nne Ar	undel place (State intry)	or Foreign
7	Director		217-72-5566 1MM 2□F 47 Yrs	. "	Months Days	Hours	No.	5v. 2.	1, Year)	6 Fra	nce	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Local	tion				<u> </u>		10d. Inside	City Limits
	Mary I she	ţo	Maryland Anne Arundel Pasaden	а							1 🗆 Y 6	s 2 No
	death with the Maryland ms 23a or 28a-f show rinust be notified at	Director	10e. Street and Number		10f. Zip Code				10g. Citizen	of What Cou	intry?	
	ath wi	ral	106 Sycamore Street		211				United	State	S	
	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	3. Wa	s Decedent of His es, specify Cubar	spanic Ori n, Mexicar	gin? (Specif n, Puerto Ric	y Yes or No an, etc.)	o- 14.	Race - Ameri Black, White		
336	urs aft	ρ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Widowed 4 Divorced Year or Dates:	1 🗆	Yes 2 No	Specify:			Spe	e <i>city:</i> Wh	ite	
Maryland 21215-0036	72 hours after natural', or Ite dical Exambra	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ceden	nt's Usual Occupa	tion	t of working		16b. Kind o	of Business/Ir	ndustry	
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2	filed within Hygiene. rther than "	CO	11 years n/a Self 17. Father's Name (First, Middle, Last)	_em	ployed	18. Mothe	er's Name (F	irst. Middle	. Maiden Sur	enter		
an	Duld be i Mental I arkad o atic eve	To Be	Robert H. Russell			Anna	м. Ра	aulus				
ary	2 should be filed withir and Mental Hygiene. Is marked other then sumatic event, I.s.M.	-		ailing i	Address (Street a	nd Numbe	er or Rural R	loute Numb	er, City or To	wn, State, Zi	p Code)	
Σ	of Health of Health of Health of Item 27 I	1			y Lane A							
Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 Is marked other then "natural", or Items 23a or 28a-1 show or other traumatic event, I. Medical Exam activate by notified at		I Bullar Zaj Cremation 3 Nemoval nom State		on (Name of tory or other place		Date			on - City or T		
Ħ.	it. Pa rtmen rtant: njury		'4 □Donation 5 □Other (Specify) Bayview	Cr	rematory				Balti		MD	
Ba	permit. Pages Department of Important: If i any injury or once.		21. Signature et Funeral Service Licensee McG422	McC	lame and Address Cully—Pol 04 Mounta	lynia	k Fun	eral l	Home,	P.A. 2112) <u>)</u>	
			23a art1. Enter the disease, or complications that ceused the death. Do not shock, or heart ailure. List only one cause on each line.	enter t	the mode of dying	alli N , such as	cardiac or re	asage. espiratory a	rrest,		Approximater Interval Be	
8760,	Medical Examiner bhysician and bhysician and the prijal-transit the prijal-transit bhysician and th	dical Examiner	Immedia. ause (Final disease or confilm resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or injury that initiated events resulting in death) Last Bue to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):		sclerotio	c car	diova	scula	r disea	ase	Onset and	
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	w requires that been signed b should be det:	by	Part II. Other significant conditions contributing to death but not resulting in the	e unde	erlying cause give	n in Part I.			obacco use d Yes 2 No			death? Unknown
Division of Vital Records,	: The law r cate has be , page 2 sh	Completed							an 24 psy prmed? 2 \(\text{No} \)	4b. Were auto prior to co death? 1 Yes	opsy finding ompletion of 2 \(\text{No} \)	s available cause of
Vita	ding Physician: 1 n. After this certifical funeral director, p	Be c	25. Was case referred to medical examiner?		Otho	P1	of Death (C					
o	Phys ar this aral di	J: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	e of	3 □ DOA 28c. Injury Work	4 🗀 Nu			dence 6 🗔		fy)	_
ion	tending leath. tor: After the funer	atio	1 Natural 5 Pending (Month, Day Year) Injur 2 Naccident investigation	У		? 'es 2	No					
Divis	in the c	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street	t, factory, office		28f.	Location (City or To	Street and Nu wn, State)	mber or Rur	al Route Nu	mber,
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de Medical Exeminer: On the basis of examination and/or and manner stated.	eath or	ccurred at the time stigation, in my opi	e, date an inion, dea	d place, and th occurred	due to the at the time,	cause(s) and date and plac	manner as s ce, and due t	stated. o the cause	(s)
	with To t	Σ	29b. Signature and title of certifier		29c. License				29d. Date sig			
			Theodor M. The man		O.C.M.	E.			Octobe	er 11,	2004	
			30. Name and address of person who completed cause of death (Item 23a) (Ty)		•		L D	1 4 2		1	2120	1
	Sta	ite	31. Date filed (Month, Day, Year) 3. Registrar's Signature	/	ll Penn S	ortee	L, Ba	TTIMO	ce, Ma	гутand	2120	T
	Registr		OCT 1 4 2004 From It A	254	K)							

			State of State of Registrar		artment of Health and M rtificate of Death		ne	32585
	Physici	an	Decedent's Name (First, Middle, Last) Fran	k J. Romec	ki	2. Date of Death Month October	Day Year 8, 2004	3. Time of Death 1:00 P M
ı	/Medic Examin		4a. Facility Name (If not institution, give street and num 4607 Kenwood Ave.	ber)	4b. City, Town, or Location of Death Baltimore City		4c. County of Death	N/A
	Funeral Director		5. Social Security Number 216-18-9779 G. Sex 1 M 2 F Usual Residence of Decedent	7. Age (In yrs. last birthday, 84 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Young) Dec. 15,	ear) Cour	lace (State or Foreign itry) yland
	Maryland -f show fied at	tor	10a. State 10b. County Maryland N/A	10c. City, Town or L	ocation Baltimore	city	1	0d. Inside City Limits 1 X Yes 2 □ No
	with the a or 28e be noti	Director	10e. Street and Number 4607 Kenwood Ave.		10f. Zip Code 21206		Citizen of What Cour	•
36	n 72 hours after death with the Maryland "neturel; or Items 23a or 28e-f show solest Examinet must be notified at	y Funeral	11. Marital Status 12. Was Dece Armed For 1/2Never Married 2 Married 1/2Never Married 1/2Ne	ces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	an Indian, etc.
Baltimore, Maryland 21215-0036	- 1 39	Completed by	3 Widowed 4 Divorced Year or Da 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	16a. Dece (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)		b. Kind of Business/Ind	White dustry
d 21	Hygirled Ther Int.		10 Years 17. Father's Name (First, Middle, Last)		Longshoreman 18. Mother's Nam	e (First, Middle, Ma	Dock Work	7
ylan	be d la la la la la la la la la la la la la	To Be	Lawrence Romecki			s Zackews		
Mar	de mar		19a. Informant's Name/Relationship (Type, Print) Miss Eleanor O. Knigh		ing Address (Street and Number or Rur Overview Circle E			Code) 7356
lore,			20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from 5	20b. Place of Disp	osition (Name of imatory or other place) Ht. of Jesus Cem.		c. Location - City or To	
Baltin	permit. Page Department of Importent: If any injury or once.		Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	3	2. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. D	Home of	Dundalk, I	
8760,	/Medical Examiner thysician and pricial-transit pricial the pricial-transit pricial the pricial transit pricial the pricial transit pricial t	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of): or as a consequence of): or as a consequence of):	ESTRUCTIVE PU	Failu	RE	
.O. Box 68	e death certific the attending p ned for use as I	Physician/Medi	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>α</u>	fuires that the signed by a lid be detach	by	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	
al Records,	The ate h page	Completed				24a. Was an autopsy performe	j prior to co	psy findings available mpletion of cause of
ion of Vital	nding Phyeicien: Th tth: :: After this certificate e funeral director, pag	ation: To Be	27. Manner of Death 28a. Date of	npatient 2 ER/Outpatie of Injury 28b. Time h, Day Year)	ont 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how		is the
Division	el or Attendi s after death. sl Director: A sd in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, s ng, etc. <i>(Specity)</i>	treet, lactory, office	281. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	(Check only 2 Medicel Examiner: On the bit one)	asis of examination and/or i	ath occurred at the time, date and place, nvestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
j	Tot Tot	Z	29b. Signature and title of scription	-wo	29c. License number 46		Date signed (Month,	
	441		5629 LONG CODNER TO	e of death (Item 23a) (Type With 18 egistrar's Signature	D36846	2116/ 13	Erran Oli	P. RAVITEM
	Sta Regist	ate rar	31. Date liled (Month, Day, Year) 0CT 1 4 2004	ogistiai s Signature	Sparker			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Vaar **Physician** Joseph F. Reday October 10, 2004 5:25 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8211 Maple Ridge Road Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Yrs. Director April 20, 1920 New York 114-10-2073 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ust be notified at 1 ☐ Yes 27 No Director Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ō 8211 Maple Ridge Road 20814 Items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examination Black, White, etc. 1 TYYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🛛 No Specify: Specify: White Be Completed by 3 X Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) Accountant Federal Government is 1 and 2 should be filed with Health and Mental Hygien tem 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Reday ပ Molly Laub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 I Earl Thorpe/Friend 833 Woodside Parkway, Silver Spring, MD. 20910 other t 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 October 15, *ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Silver Spring, Maryland Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licens M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Bronchogenic Carcinoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence of a Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physiclan/Medical the IF FEMALE: esr 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 X No 1 Yes 2 No 1 🗌 Yes of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 XNatural 5 Pending investigation death. 1 🗌 Yes 2 No 2 Accident Director 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide hours after within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl of certified D 26571 October 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1 Irving Mizus, M.D., 10215 Fernwood Road #401, Bethesda, MD. 20817 31. Date filed (Month, Day, Year) 0CT 1 4 2004 32 Registrar's Signature State Registrar

Donna Roesler

			Please	Type or Print in Blac State of Maryland /			_	ible.
		-	For State Registrar	State of Maryland	Certificate of L		Reg. No.	1. 99607
			Decedent's Name (First, Middle, La	st)		2. Date of	Death	3. Time of Death
	Physicia		Donna Roesler			Month	Day	2004 3:53 AM
	/Medic		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or	Location of Death		y of Death
			Good Samarit	an Hospital	Bal	Himore		
	uneral Director		5. Social Security Number 6. S 214-68-3111	ex 7. Åge (In yrs. last b □ M 2风F 49	irthday) If Under 1 Year Yrs. Months Days	Hours Min. 8. Date of (Month, Mar 3	Birth Day, Year) 0, 1955	9. Birthplace (State or Foreign Country) Maryland
pur	≥		Usual Residence of Decedent 10a. State 10b. County	10c City To	wn or Location			10d. Inside City Limits
G Z IZ I 3-UU30 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiens. Importment if them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examinar must be notified at once.	ctor	MD NO. County		Baltimore			1 X Yes 2 □ No
ë Ë	or 28	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of	What Country?
ath w	23a	ral	8720 Emge Road		2123			JSA
ar de	tams	nne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hi If Yes, specify Cuba 	spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.)	No- 14. Ra	ce - American Indian, ack, White, etc.
s afte	, or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:	Speci	y: white
3 mg	al E		15. Decedent's E		a. Decedent's Usual Occupa	ation	16b, Kind of E	Business/Industry
F 72	n "na Meedlik	plet	(Specify only highest grant Elementary/Secondary (0-12)		(Give kind of work done of life. DO NOT use retired	furing most of working		,
d with	grena er tha	Completed	9	0	clerk		fa	st food
5 🚆	al Hy I othe vant,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Mid	dle, Maiden Suma	me)
ould to	Ment arkec	2	Anthony Guido	v		Pearl White	2	
2 sho	ls m		19a. Informant's Name/Relationship (b. Mailing Address (Street a	and Number or Rural Route Nu	mber, City or Town	n, State, Zip Code)
1 and	or Health a		Richard Hyer/bro		1721 Hamilto	n Place White		
Pages 1	or of		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State cemet	of Disposition (Name of ery, crematory or other place	e) Date	20c. Location	- City or Town, State
rmit. Pages	rtant		' 4 □ Donation 5 ☒ Other (Special		On Name and Address			
Dem Dem	Impo any ii		21. Signature of Funeral 9, ryice Lice Roll of S	ade Virty	22. Name and Addres	omy Board 655 t	V. Baltin	ore Street
			23a. Part 1. Enter the disease, or com	plications that caused the death. Do	Baltimore,		y arrest.	Approximate
D.			shack, or heart failure. List only Immediate Cause (Final	one cause on each line.			,	Interval Between Onset and Death
	ysician /ledical		disease or condition resulting in death)	a Due to (or as a consequence	ot).			
Ex	aminer			. Weerphiz	ing fascill	45		-
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J, executed	ian and urial-transit	Examlner	Cause (Disease or injury that initiated events	C				
	an ar ırial-t	EX	resulting in death) Last	Due to (or as a consequence	e of):			
ficate be	hysic he bu	Ical		_ d				
	ing p	Physician/Medl	IF FEMALE:					
death cer	or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deal				ate of delivery onth Day Year
. e	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			
The law requires that the	been signed by the attending physici should be detached for use as the bu	h h	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause give	en in Part I. 23e. D	id tobacco use cor	stribute to the cause of death?
CS,	sign d be	d by	Tasulia Denen	lent Diabetes K			☐ Yes 2 ☐ No	3 ☐ Probably 4 🗗 Cinknown
	peed	Completed	Darial unal 1000			24a. W	Mas an 24h	Were autopsy findings available
19 Bd	has le 2	mp	Periphera Vas	cular Disease		a	utopsy erformed?	prior to completion of cause of death?
	certificate rector, pag	o C	25. Was case referred o medical	ry Pisease.		1 ☐ Ye		1 ☐ Yes 2 ☑ No
Q5	n. After this certific funeral director,	o B	examiner?	Hospital: 1 Impatient 2 ER/C	Othe			har (Specific)
2 E	eral dii	L :	27. Manner of Death		Time of 28c. Injury	at 28d. Descri	be how injury occu	
VISION	atn. r: After e funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Work	res 2 □ No		
VIS r Atta	ractor: by the	ertification;	3 Suicide 6 Could not be determined		farm, street, factory, office		n (Street and Num Town, State)	ber or Rural Route Number,
iai o	ai Di	O	_					
75			29a. Certifier 1F Certifying Pl	nysician: To the best of my knowledge	ne, death occurred at the tim	e, date and place, and due to t	he cause(s) and m	
Hos	24 hour Funara stely fills	dica	(Check only 2 Medical Examone)	niner: On the basis of examination a and manner stated.	nd/or investigation, in my op	pinion, death occurred at the tin	ne, date and place,	anner as stated. and due to the cause(s)
To the Hosp	within 24 hours affer death. To the Funaral Diractor: Affer completely filled in by the funer	Medical	(Check only 2 Medica! Exa	niner: On the basis of examination a	nd/or investigation, in my op	oinion, death occurred at the tin	29d. Date signe	anner as stated. and due to the cause(s) and (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

books

Blud Baltimore, MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khaled Hassan 560 Loch Raven

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OCT 1 4 2004

		1 = For State Registrar	State of Ma	arylan			f Health ar of Death	nd Mental Hy	/gien Reg. N	13 13	01.	22200
Physicia /Medica		1. Decedent's Name (First, Middle, La MILDRE	5.	S	LEC	H7		2. Date of D	eath	<u>د</u> ک	Year 2,004	3. Time of Death 5:30A M
Examine	er		ALTH OF		AIR	BE		<	4	-	of Death	RD
Funeral Director		5. Social Security Number 6. S 211-22-0123 Usual Residence of Decedent	ex Z Age	(In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Da		Min. 8. Date of Bi	rth ay, Year	27	9. Birthpla Counti	ace (State or Foreign
death with the Maryland ms 23s or 28e-f show I'must be notified at	tor	10a. State 10b. County MD. Hay Fr	- DRD	10c. City	Town or Lo	cation					10	d. Inside City Limits
with the	Director	10e. Street and Number	TCn		25	10f. Zip Cod	le		10g. C	itizen of 1	What Countr	y?
urs after	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		lf	Vas Decedent Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)	ò-	14. Rad Blad Specify	e - America ck, White, et	n Indian,
21215-003 ad within 72 hours giene. er then "naturel", the Medical Ex	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5-	+)	(Give I	ent's Usual Ockind of work do	cupation ne during most o tired)	f working			usiness/Indu	,
De file dott	lo Be C	17. Father's Name (First, Middle, Last)	STEVER	25			ELi.	Name (First, Middle	, Maidei	Suman DK	NE	K
and 2 sh and 2 sh salth and n 27 is rr	4	DANLEDE T	Type, Print) VIDN		19b. Mailing	Address (Stre	eet and Number o	Poil	er, City	or Town,	State, Zip C	Code)
Baltimore, sermit. Pages 1 ar Department of Hea mportent: If them my injury or othe more.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Pla	ace of Dispos	ition (Name of atory or other)	Pace)	Date 12	20c./	ocation -	City Tow	n, State
Balti permit. Departm Importe eny inju		21. Ignature of uneral Service Liden		D.	. 3	Name and Ad	dress of Eacility	2829 BALI	140	P50	30	724
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Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician Medical Examination		Sequentially list conditions, if any, leading to immediate cause. Enter Undervin Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a									
K 68760, ertificate be expling physician e as the burial	No.	IF FEMALE:	d						Ŧ			
y, P.O. Box (s) that the death certificated by the attending of detached for use as) siciality	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal	death 3 □E	Ectopic pregnar Other <i>(specify)</i>	ncy			23d. Date Mor	e of delivery ath Da	ay Year
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		25. Was case referred to medical						1 ☐ Yes	sy med? 2 X No	d d	/ere autopsy rior to compleath? Yes 2	r findings available letion of cause of
Vision of Vita Attending Physicien: In death. ector: After this certifica by the funeral director. I	2	examiner?	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day	2	R/Outpatient 8b. Time of Injury	28c. In	Other: 4 Nursin	Death (Check only only only only only only only only	lence			
IVI Pratition irec propried		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At hom (Specify)	e, farm, stree			28f. Location (S City or Tow	itreet an n, State	d Numbe)	r or Rural R	oute Number,
DIVI To the Hospital or At within 24 hours after or To the Funeral Direc completely filled in by Medical Certifit		29a. Certifier (Check only one) Certifying Phy	rsician: To the best of iner: On the basis of e and manner state		edge, death on and/or inve	occurred at the stigation, in my	time, date and pl opinion, death o	ace, and due to the o	ause(s) late and	and man place, a	ner as state	d. e cause(s)
To th within To th compl		29b. Signature and title of certifier	N			29c. Lice D34	nse number		_		(Month, Day	
Ψ		30. Name and address of person who co	ompleted cause of dea	ity (Item 2	3a) (Type, Pr	rint)	Rel 1	iv Mar	10		, <u>jo</u>	1000
State Registrar		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar	s Signatu	0		37 7	11 017	7	VG	~ /	

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		í	1 - For State Registrar	State of Maryla		artment o			and Me		iene	nn.	32589
	Diversity.		1. Decedent's Name (First, Middle, Las	st)		-			2	. Date of Deat Month	h	Year	3. Time of Death
	Physici /Medic		MARIE J. S	WIDERSKI						OCTOBER	Day 12	2004	8:05 P M
	Examin		4a. Facility Name (If not institution, give			4b. City, To					4c. C	ounty of Dea	ath
			421 IRENE DRIVE		un de est brûeth de co			BURN If Under 2		0 . (5)4			RUNDEL
П	Funeral Director		5. Social Security Number 6. S 213–18–0310	D M 200 7. Age (/// y.	rs. last birthday) 3 Yrs.			Hours		Date of Birth Month, Pay 2.3/191	Year)	9. BII	nthplace (State or Foreign ountry) RYLAND
	100		Usual Residence of Decedent							, 2.3 / 1 / 2			TT STITED
	how Let		10a. State 10b. County		City, Town or Lo								10d. Inside City Limits
	Ba-fs	cto		RUNDEL	GUEN I	BURNIE							1 ☐ Yes 2 ☐ No
	vith th	Director	10e. Street and Number			10f. Zip Co				16	-	on of What C	ountry?
	s 23s	rai	421 IRENE DRIVE	10 Was Davidson Sussia	11.0		2106					SA L	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiane. If health and Mental Hygiane. And T Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Example in the Invitible at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ ▼ dowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates:	- 1	Was Deceden If Yes, specify 1 ☐ Yes 💥			jin / (Specii , Puerto Ric	ry Yes or No- can, etc.)		Black, Whi	erican Indian, te, etc. HITE
ŏ	2 hou	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual C	Occupation	on			6b. Kind	of Business	/Industry
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21	filed wil Hygien other the		8		HO	MEMAKEF						VN HOM	E
	be fil htal H ed oth	Be	17. Father's Name (First, Middle, Last) THOMAS DANIE				18		r's Name <i>(F</i> Y RADI	First, Middle, N V C	fa <i>iden S</i>	umame)	
<u> </u>	2 should be and Mental Is marked aumatic ev	ဥ	19a. Informant's Name/Relationship (7		10h Maili	na Addrass (S	Stroot and			Route Number,	Cityon	Tour State	Zin Codo)
<u>⊠</u>	od 2 s lith an 27 Is : traus		DOLORES JAMISON							URNIE:			Zip Code)
ē,	s 1 and 2 f Health Item 27 othar tra		20a. Method of Disposition	200	p. Place of Dispo cemetery, cre	sition (Name	of		Date				Town, State
Ë	Pages nent of P ant: If its ury or of		X Burial 2 □ Cremation 3 □ `4 □ Donation 5 □ Other (Specify	Removal from State	LEN HAVI			1(0/16/2	2004	GLE	N BURN	IE, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funer 1 spice Licen	see O	2:	2. Name and A	Address	of Facility	FIN	K FUNER	Aī I	HOME , I	PA
m —	89 = 8		KELLY CREGORY	F.OK #M01148	4:	6 CRAI	IN H	IGHWA	AY S.	, GLEN	BUR	NIE, M	D 21061
	Pnysician :		23a. Part1. Enter the disease, or composition, or heart failure. List only immediate Cause (Final disease or condition	olications that caused the de one cause on each line.	eath. Do not en	ter the mode o	of dying,	such as o	cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a cons	ence of):	4.2.	90	1	100	120			(1) y
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89	ntifica ng ph as th	Medi	IF FEMALE:								-		
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 Fe	etal death 3[⊒Ectopic pregr					23	d. Date of de Month	livery Day Year
- 0	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time o 9☐ Unknown	of death 5	Other (speci	rfy)						-u, ,
a.	The law requires that the de ate has been signed by the a page 2 should be detached f	/ Ph	Part II. Other significant conditions of	ontributing to death but not r	resulting in the u	nderlying caus	se given	in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
Records,	quires n sigr ald be	d by								1 🗆 Ye	2 🗆	No 3□Pi	robably 4 Unknown
000	aw require s been sig s should b	ojete								24a. Was an		24b. Were at	utopsy findings available
H	The tav ate has page 2:	Completed								autopsy perform 1 Tes	ed?	death?	completion of cause of
		Be C	25. Was case referred to medical examiner?				2	6. Place	of Death (C	Check only one			
	his Il di	2	1 □ Yes XX No		☐ ER/Outpatier				-	XX Resider			cify)
Division of	I or Attanding P after death. Director: After t I in by the funera	ion:	27. Manner of Death 1 ☑ Watural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Work?			d. Describe how	v injury (occurred	
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<u>^</u>	al or A safter I Direction by	Certification:	4 Homicide determined	building, etc. (Spe	eify)	cot, ladory, o	moe		2011	City or Town,	State)	va,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	siai i logio i variboi,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai (29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam- and manner stated.	knowledge, deat ination and/or in	h occurred at t vestigation, in	the time, my opini	date and ion, death	place, and h occurred	due to the car at the time, da	use(s) ar te and p	nd manner as lace, and due	s stated. to the cause(s)
	To th To th Comp	ž	29b. Signature and title opportifier	Mari)	29c. L	icense n	umber	1,4	29	d. Date	signed (Mont	h, Day, Year)
	7		a find	11/16			//	111	1	6	10	toba	14,2004
	W		30. Name and address of person who	completed cause of death (II	tem 23a) (Type,	Print)	11)rivio	0 /	/ 1	Rin	, ,	1.71061
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Registrar

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Sanders, William Baltimore, Maryland 21215-0036 Phys /Me Exa To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

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				Indelible Ink. Ensure epartment of Health and	-	_
		1 - State Registra AMEND ITEM	/20b PER FH G836 1	•	Reg.	2001 00501
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/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	OCTOBEY ath	1\ 2004\10:27
		Franklin So	uare Hospital	Rosedale		Baltimore
Funeral Director		5. Social Security Number 6. Se 2. \$1. 18. 3154	MAL OFF	nday) If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Foreign Country)
D		Usual Residence of Decedent 10a. State 10b. County	100		D. 1.1	130 SOUTH CHRUCHYN
be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or Items 23a or 28a-f show event, I're Medical Exercifear mast be inclified at	ro	10a. State 10b. County	10c. City Town	TIMORE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th the	Funeral Director	10e. Street and Number	1	10f. Zip Code	10g.	Citizen of What Country?
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r Item	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 M No	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, It a Madical Exaction of the notified at ance.	Be	17. Father's Name (First, Middle, Last) LARENCE HA	INNAH	18. Mothers Na	ame (First, Middle, Maid	en Sumame) ANIDERS
should ind Men s marks umatic	ပူ	19a Informant's Name/Relationship (7	ype, Pring 19b. I	Mailing Address Street and Number or F	Rural Route Number, Cit	y or Town, State, Zip Code)
and 2 ealth a m 27 is		KUTH S. WHIT	re MOTHER S	810 KICHMOND	AVE. BA	TIMORE, MD 21234
Pages 1 nent of Hi ant: If itan		20a. Method of Disposition 1 D Burial 2 Cremation 3 C	nemovar nom State	Nosition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	1001.20	22. Name and Address of Facility	WOHN C BI	PCI I MOKE, INITIAL HAND
permit. Departi		> Vaux	ha prese	4905 YORK ROAD	BAUTIMON	RE, MARYLAND 21212
			lications that caused the death. Do not one cause on each line.	ot enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acute WII Due to (or as a consequence of	1.		0.130(4.10 B024)
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death c attend	iclan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
The law requires that the death certificate be exe ate has been signed by the attending physician a page 2 should be detached for use as the burial-	Physiclan/Medical	9 Unknown	9□ Unknown			
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oltal or Att urs after d iral Diract iled in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 Yes 2 No n, street, factory, office	28f. Location (Street and City or Town, Sta	ury occurred and Number or Rural Route Number, te)
To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director.	edical Certifica	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	ury Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Street. City or Town, Sta	and Number or Rural Route Number, te)

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State Registrar

128

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Suni Ahuja 9000 Franklin Square Drive, Baltimore M.). 21237

31. Date filed (Month, Day, Year)

32. Registrar's Signature

GCT 1 4 2004

Aparks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 0213 SCOTT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAUSBURY, Wiconico HOSPICE AT MD THE LAKE 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) 1□ M 20 F Months Days Hours Yrs. Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Centenary Drive 21804 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard A. George Rebecca E. Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Centenary Drive - Salisbury, Maryland 21804 of Disposition (Name of Date 20c. Location - City or Town, State Joseph L. Scott (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑NBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park 10/11/04 Crisfield, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Bradshaw & Sons Funeral Home Mary Beth Bradshaw-Pruitt 306 W. Main Street - Cris 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main Street - Crisfield, MD 21817 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 → Wo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

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attending physician I for use as the buria

page 2 s

funeral director,

filled in by the

The law requires that the death certificate be executed

or Attending Physicien:

Hospital 24 hours

efter death. Director: After this

within 2

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

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Director

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Examiner

Physician/Medical

Completed by

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Certification:

Medical

Funeral

Director

ortant: If Item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural" or health illy or other trainment.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?
1 Yes 22. No

1 atient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 28a. Date of Injury 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cert

OCT 1 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COURVE 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** 628 PM Garland Nelson Shifflett October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris @ Mercy Baltimore City N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 XM 2 ☐ F Yrs. Director Aug. 9,1946 Maryland 212-44-1251 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show and insertives at Baltimore Edgemere Maryland 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8029-A Shore Road 21219 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ⊠Yes 1 ☐ Never Married 2 Married 2 🗆 No 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Vietnam 7 is marked other than "natural", o traumatic event, the Modeul Exer-Ď 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Assembler General Motors, Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Ollie M. Shifflett June Lorraine Counts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Diana R. Shifflett/Wife 8029-A Shore Road Edgemere, Maryland Health If item 27 21219 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c Important: If any injury or once. ŏ Oak Lawn Cemetery 10/11/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 1 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rome Hears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s 2XI No 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hoffice 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a cai 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I ths 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 MO

Registrar

State

32. Registrar's Signature

3015T,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHI-SHIANG

31. Date filed (Month, Day, Year)

OCT 1 4 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 00:14AM Catherin € OCTUBER Margare 12 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA Baltimore Melical Center Many If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Director May 25, Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is markad othar than "natural", or Itams 23a or 28a-f show traumatic avant, the Medical Examinat must be midified at Maryland Anne Arundel Baltimore 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S. 625 Lorca Avenue death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Imhoff Rose M. Boeh 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 Is jury or othar trau Jeanette Roberts / Daughter 6801 Gravel Branch Road Hurlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department Important: If any injury o Cedar Hill Cemetery 10/16/2004 *4 □ Donation 5 □ Other (Specify)

21. Signature of Ferral Service Ligand Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician cerebrovacular accident disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter and anying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 TYAS To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: P 1 ☐ Yes 2 No 12 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pendina after death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To tha Funaral Diract completely filled in by 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD omes who completed cause of death (Item 23a) (Type, Print) 225 liveene St. Baltimore Komina nomes MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 07:50 P M 2004 10 10 Emily Nadyne Stauch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel 116 Governor's Court Apt. A 8. Date of Birth (Month, Day, Year) 12/10/1921 Birthplace (State or Foreign Country)
 TD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 218-12-2642 82 Yrs MD Director Usual Residence of Decedent . Pages 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hyglene. It tant: If item 27 is marked other then "netural", or Items 23a or 28e-f show jury or other treatmatic event, Ite Mydfoal Extra or must be notified at jury or or other treatmatic event, Ite Mydfoal Extra or must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No Anne Arundel Glen Burnie Directo 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 116 Governor's Court, Apt. A 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone telephone operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Laura Lee Wilson Leonard Osborne Langford ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John C. Stauch/husband 116 Governor's Ct., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 10/12/2004 Stevensville, MD permit. Page Department of Important: If any injury or 2002e. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilitySingleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Physician ESOPHAGOAL /Medical Due to (or as a consequence of): Examiner UNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be RHEVMATORD ARTHUMS 1 ☐ Yes 2 4No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 2 □ No 1 Tes 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No ပ 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? : After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 \(\text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AZ1 336 10/11 104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. LBIN O. KUHN I BOZB RITHER HWY, PASADENA, 32. Registrar's Signal 31. Date filed (Month, Day, Year) State 4 1000 th Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 12 John Joseph Scarbrough 2004 8:10 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Towson Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 21, 1922 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1**X** M 2 □ F 214-16-5277 82 Yrs. Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

ant: If item 27 ie marked other then "natural", or Items 23e or 28e-f ehow Liry or other treumatic event. Its Muckel Exprinter must be notified at try or other treumatic event. Its Muckel Exprinter must be notified at 10c. City, Town or Location 10a. State 10b. County 7 is marked other then "natural", or items 23e or 28e-f ehow treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 21 No Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1202 Stevenson Lane 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Analyst Federal Housing Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P John L. Scarbrough Anna M. Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Scarbrough/ Son 1202 Stevenson Lane Towson, Md. 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 10-16-04 `4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Timonium, Md. 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home 1050 York Rd. Towson, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐ Pregnant at time of death Day 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records. 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No Hospital or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner examiner? Other: 4 Jursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 29a. Certifier 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO leted cause of death (Item 23a) (Type, Print) 30. Name and address Greene Tree Pel Hemen Pegistrar's Signature OC. Registrar

			1 - For State Ragistrar	State of Ma		artment o		nd Mental Hy	giene Reg. No.	001	9251	9.7	
	Physici /Medic		1. Decedent's Name (First, Middle, Las Adeline Holl	•	owden			2. Date of De Month OCTODE	ath	ž004	3. Time of I	Death PM	
	Examin		4a. Facility Name (If not institution, give	ice House		Li	n, or Location of nthicum		A	County of Death nne Arun			
	Funeral Director		5. Social Security Number 220-09-1224 Usual Residence of Decedent	ex 7. Age	(In yrs. last birthday 84 Yrs.) If Under 1 Ye Months Da		Min. Jan. 01	19, Year) 1 192	9. Birthp Coun	lece (State or try) MD	Foreign	
	e-f show	ctor	10a. State 10b. County Maryland Anne Ar		10c. City, Town or L		asadena			11	0d. Inside City 1 ☐ Yes		
	with the 3e or 28	i Director	10e. Street and Number 310 Claiborne Roa	ad		10f. Zip Co	21122		10g. Citizen of What Country? USA				
980	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "naturel", or Items 23e or 28e-1 show event, I'm Medical Evert as riust be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 [] Yes 2 [X] No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent If Yes, specify C	of Hispanic Origi Cuban, Mexican,	in? (Specify Yes <i>o</i> r No Puerto Rican, etc.)		4. Race - Americ Black, White,			
Maryland 21215-0036	within 72 ho ane. than "natur to Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	edent's Usual Oc e kind of work do DO NOT use re	ne during most (tired)			6b. Kind of Business/Industry Railroad			
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	he Hosp n 24 hou he Fune pletely fil	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of niner: On the basis of e and manner state	xamination and/or ir	th occurred at the rvestigation, in m	e time, date and ly opinion, death	place, and due to the occurred at the time,	cause(s) a date and p	ind manner as sta place, and due to	ited. the cause(s)		
•	1	W	29b. Signature and title of certifier	1.D.		29c. Lice	542	92	29d. Date	signed (Month, D	ay, Year)		
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			1 - State Amend Item 18	State of Maryland (Dec per Th 6836 10-18 Ce	eartment of Health and ertificate of Death	d Mental Hy	giene	. 99cno
			Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
	Physici		Issa Mousa Sa	ah		Octobe		ear 4 9:48 P M
	/Medic Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of De		4c. County of	
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 F		rth 9.	Birthplace (State or Foreign
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	pu 🗼		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	tion			1011
	sho	5						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	r Item	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)		White, etc.
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show fra Madical Evartirat must be rotified at	Completed	15. Decedent's Educ		edent's Usual Occupation a kind of work done during most of v		16b. Kind of Busin	ess/Industry
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23s or 28e-1 show any injury or other traumatic event, the Medical Examination must be notified at once.		19a. Informant's Name/Relationship (Typ		ing Address (Street and Number or		-	
	t and Health em 27 ther tr		Faris Saah/ Son 20a. Method of Disposition	20b. Place of Disc	naling Road, Dar		1ecticut U 20c. Location - City	
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Ba	permit. Departr Importe any inju		1 Don 25	M01405 B	2. Name and Address of Facility R ethesda-Chevy Ch ethesda, Marylan	ase Inc	. 7557 Wis	sconsin Ave.
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	To the Hospital or Ai within 24 hours after or To the Funeral Direc completely filled in by	edical	29a. Certifier (Check ofly one) 1 Certifying Physical Examin	ician: To the best of my knowledge, dear er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and pla evestigation, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	o the	Me	29b. Signiture and title of certifier		29c. License number		29d. Date signed (M	onth, Day, Year)
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	in		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type.			11/10	,
	10		Michael N. Solomon			evy Chas	e, MD 2081	15
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Registrar

OCT 1 4 2004

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death RegistramEND ITEM #19b PER FH C836 10/14/04 JH 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 218 a M **Physician** Detober SYLVIA SYBERT 2004 /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number 4c. County of Death Examiner Bultinoal Maryland Greneral 40spital N/A 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1□ M 2₩ F 91 MD 217-05-6693 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at MD BALTIMORE TOWSON 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 812 REGESTER AVE. 21239 USA or items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗶 No Baltimore, Maryland 212†5-0036 Specify If Yes, Give Year or Dates: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE "natural". 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) ADMINISTRATOR ADVERTISING AGENCY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental I SHECTER STETSKY LENA ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33436 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum 2002. 4109 ALPINA COURT NORTH - BOYNTON BEACH, FL SARA KREPS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY 10/13/2004 WOODLAWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RIMARY **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner **burial-transit** death certificate be executed no ation and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) detached P.O. δ The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying-equise given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Gastrointestinal pe 4 Uhknown 1 TYes 2 🗆 No 3 Probably been Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 4 No has page 2 certificate 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Anpatient 2 ER/Outpatient Medical Certification; To 3 DDA this within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide ö To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Macem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), HEEM AMATUN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 4 2004 Registrar

rn			For Unpend Item 23 State Capacitar Amend Item 2	State of Mar 8a-f per	yland/Mepe me G83 <i>Pei</i>	idgento tificate d	theath and North Death 11-	lental Hygie 16-04 t <mark>as</mark> .	ne No. 101	32501
	Physici		Decedent's Name (First, Middle, Last) CAR		EBECCA		RSKY	2. Date of Death	°62, 20°64	3. Time of Death 12:43 PM
D	/Medio Examin		4a. Facility Name (If not institution, give str				n, or Location of Death	1	4c. County of Death	1
0			6603 Doral Drive				imore		N/A	
145	Funeral Director		330-00-6373	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Ye Months Da		8. Date of Birth (Month, Day, Ye MAY 11,	1956 9. Birth	nplace (State or Foreign untry) MD
7	land ow		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mary 8-f sh	tor	MD N/A				BALTIMORI			1 X Yes 2 No
	ith the or 284 e not	Director	10e. Street and Number			10f. Zip Cod		10g.	Citizen of What Co	*
	s 23e		6403 DORAL DRIVE	#C	:-11.0	Mar Brandani	21209	N	14 Page Amer	USA
136	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, I'm Medical Examinating mouther and the notified at another.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 MidDivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, If Yes, specify Cuban, Mexican, Puerto Rican, If Yes, specify Cuban, Mexican, Puerto Rican, If Yes, Specify Cuban, Mexican, Puerto Rican, Puerto Ric						14. Race · Amer Black, White Specify:	
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N.	Physician: this certific al director,	o Be	25. Was case referred to medical examiner?	spital:	0.57.50.0		04	h (Check only one)	X-0.1	ify) at scene
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	within compl	Me	29b. Signature and title of certifier	,		29c. Lic	ense number	29d.	Date signed (Month	, Day, Year)
	fo the Hospital or Attency, within 24 hours after death To the Funeral Director:		> Unell-				O.C.M.E.	Oc	tober 03,	2004
	O By		30. Name and address of person who com	1310, MD) 111	Print) Penn S	Street, Bal	timore, M	Maryland 2	1201
	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar	s Signature	Spor	KN			

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		Stata Registrar				Ce	ertificate o	f Death		Reg	No.	anh	37602
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di		30. Name and address of	-		RO/		STAINS	The m	Dall	50 1	NID	18/1001	+10 C
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Physici		1. Decedent's Name (First, Middle, Last) Marie Marie	n Totaro				2. Date of De Month ()c tober	ath Day	Year	3Time of Death		
/Medic Examin		4a. Facility Name (If not institution, give sta	7 70 100		4b. City, Town, o	r Location of C	10.0	7	County of Death			
Funeral Director		212 10 2514	7. Age (In yrs. I. 91	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month. Da	th 1 <i>y, Year)</i> 5, 19	Cour	place (State or Foreign htry) ryland		
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2 should be filed within 72 hours after death with the Maryland and Meanlar Hygiene and Meanlar Hygiene is merked other than "natural; or Items 23s or 28e-f show aumatic event, its Medical Examiner must be netilited at	by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H I Yes, specify Cuba 1 ☐ Yes 2X No		- 1	14. Race - American Indian, Black, White, etc. Specify: White				
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and 2 shores and 2 shores and 2 shores and 3		19a. Informant's Name/Relationship (Type Lucille Bradshaw			ng Address <i>(Street</i> Brian Stre			-	r, City or Town, State, Zip Code) Maryland 21225			
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome ol pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time ol death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year			
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 2004 Month : 054M **Physician** Motell Towns 9 XTOREN /Medical 4b. City. Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) unknown **Funeral** Days 12 M 2□F Hours Min. 85 Yrs Director 216-12-8471 11-06-1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be excitled at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore MD X Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21216 2774 W. North Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) UΠΙΚΠΟΨΩ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unknown Elementary/Secondary (0-12) College (1-4or 5+) 6 18. Mother's Name (First, Middle, Maiden Sumame) unknown 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Artie Shaw/ Guardian 10 N. Calvert St. Balto, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-14-04 Mt. Zion Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, MD 21. Signature Funeral Svice Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) URINARY IRACT Priysician WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): by Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed SEIZURE DISORDER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 210 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😾 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After To the Hospitel or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title-of-certifier 29d. Date signed (Month, Day, Year) D006/765 OCTOBER 9 2004 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEACH CAME 900 CATON AVE BALTIMONE QUANNOO ST Mants EKENFLEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 4 2004 Registrar

MOLELL

			For State Registrar	State of Ma	aryland /		artment rtificate			and M		gienę Reg. No.	211111	32605
1	D1		1. Decedent's Name (First, Middle,	Last)							2. Date of De. Month	ath Day	Year	3. Time of Death
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	Examir		4a. Facility Name (If not institution,	give street and number)			4b. City, To	own, or	Location o	of Death		4c.	County of Deat	h
			1600 Mt. Royal	Ave. Apt.	. 404		Ba	alti	imore			ļ	NA	
	Funeral				e (In yrs. last b		If Under 1 Months	Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Da	h v. Year)	9. Birt	hplace (State or Foreign untry)
	Director		095-24-8235	1□M 2 X F 7	4	Yrs.					10-3-			S.C.
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36	I', or	by F	3 ☐ Widowed 4 🏋 Divorced	d 1 ☐ Yes 2√ N If Yes, Give Year or Dates:	40		1□Yes 🗶	□ No	Specify:				Specify: F	Black
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Hems 23a or 28e-f show that the Medical Evar in writhust by Indiffied at	ed	15. Decedent's	Education	166	a. Dece	dent's Usual	Occupa	ation			16b. Kir	nd of Business/	
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212	y withi	Completed	12th grade	College (1-4or 5 2 yrs		ırsi	ng Tra	ing	Supe	rvis	or	Woo		Handicap
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28e-1 show may injury or other treumetic event, the Medical Ever. in vermissible rediffied at ance.	-	19a. Informant's Name/Relationshi	p (Type, Print)	19	b. Mailir	ng Address (S	Street a	and Numbe	r or Rura	l Route Numbe	r, City or	Town, State, Z	ip Code)
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ore	of He		20a. Method of Disposition		20b. Place cemet	of Dispo	sition (Name	of er place	9)	D	ate	20c. Lo	cation - City or	Town, State
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o once.		1 XBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe			-	awn Mei		· <u>I</u>	n 1	0-16-04	Is	elin, N	i.J.
alti	permit. Departn Importe eny inju		21. Signature of Funeral Service Li	censee		22	. Name and	Addres	s of Facility		-		e, Md.	21202
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	/Medical		resulting in death)	a Due to (or as:	a ponsequence	of):	C 0	ما ما	u J		1			
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	the de	ysic	1 ☐ Yes 25 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5L	Other (spec	:rfy)						
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3ec	has has	Completed	- Hopp	erquisu	277						24a. Was a autop perfor	sy	prior to c death?	opsy findings available ompletion of cause of
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	To th within Fo th compl	Me	29b. Signature and little of certifier	131			29c. L	icense	number		2	9d. Date	signed (Month	Day, Year)
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	0		30. Nam an address of person w	n, completed cause of de	eath (Item 23a)	(Type,	Print)			9		10	1, 41	7/2/2
			Indius	F. Green	MOM	d	315	S.L.	1. Ca	Ulu	# St	Bay	tunere	MDaire
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. . Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBER 12, 2004 **Physician** GRACE REGINA WYMBS 1944 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY BETHESDA SUBURBAN HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NEW YORK 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Months Days Hours Min 1 □ M 2 X X 82 Yrs. 3/1/1922 Director 098-12-9850 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes XX No MONTGOMERY MD CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5555 FRIENDSHIP BLVD. APT 431 USA Items 23a 20815 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Itel any injury or other traumatic event 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X2 No Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VINCENT FOSTER MARY DOYLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA WYMBS 8218 CEDAR STREET, SILVER SPRING, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State GATE OF HEAVEN CEM 10/16/2004 HAWTHORNE, NY 4 ☐ Donation 5 ☐ Other (Specify) o Fineral Service Licens 22. Name and Address of Facility FINK FUNERAL HOME 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 INK #M01148 23a. Part1. En or the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA 1 WEEK /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No ŏ Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No XX No 1 Yes 1 TYAS of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes XXNo 2 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Division 1 Matural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct XXI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26259 10/13/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVA KAUFMAN, MD 8218 WISCONSIN AVENUE, BETHESDA, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

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	_		Registrar 1. Decedent's Name (First, Middle, Last)	1	Cei	tillicate of L		Reg. 2. Date of Death	. No.	3. Time of Death		
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			5. Social Security Number 6. Sec		s. last birthday)	If Under 1 Year		8. Date of Birth	N/A	(0.4. 5		
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	or 28a	Director	10e. Street and Number		Cı	10f. Zip Code	01000		. Citizen of What Cou	ntry?		
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36	d within 72 hours after death with the Maryland Jiene. r then "natural", or items 23a or 28a-f show the Medical Examinar must be muffled at	by Funeral	11. Marital Status 1 □X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: 1,71			
9	2 hour	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	tion	168	b. Kind of Business/In			
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land	be filed tat Hyg d other event,	To Be C	17. Father's Name (First, Middle, Last)	Kim Sing Wo	ng		18. Mother's Name (Marie	First, Middle, Mai Wong Be1	,			
Maryland	nd 2 alth ar	-	19a. Informant's Name/Relationship (Ty ArthurB. Wong (_{pe. Print)} Brother)			nd Number or Rural enue, Balt		ity or Town, State, Zip	Code)		
Baltimore,	of Health of Health f Item 27		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □R		cemetery, crer	sition (Name of natory or other place	Da Da		c. Location - City or To			
ţim	t. Pages tment of i tant: If It		' 4 ☐ Donation 5 ☐ Other (Specify)	1	oudon F			/2004 Ba	ltimore, M	laryland		
Bal	permit. Pages Department of I Important: If Its any Injury or o		21. Signature of Fundral 3 ervice License 23a. Part1. Enter the disease, or compli	Kevin E EC	I M	Name and Address IcCully-Po 30 E. For	lyniak Fu	neral Ho	me, P.A.	30		
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certiflier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my opi	e, date and place, an nion, death occurred	d due to the cause at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)		
	with vith com	Σ	29b. Signature and title of certifier	OTABA HATA		29c. License			Date signed (Month, I			
•	/X)			RTAZA KAZA			17610.	00	JOBER 11,	2604		
1	(D)		30. Name and address of person who co		ATON A		VES HEALT	H CARE. F	BAUIMORE,	MD 11229		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	Sport						
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** OCTOBER 09 2004 MELVA LOUISE WILKENING 2:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel 5 WILLS AVE. **FERNDALE** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 □ M 2 1 F 216-14-0907 90 Director Oct 14. Maryland Usual Residence of Decedent 10c. City, Town or Location 10h County 10a State 10d. Inside City Limits or 28a-f show ust be notified at Maryland Anne Arundel Ferndale 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 5 Wills Avenue USA or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after de al Hyglene. I other than "natural", or Item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Sears. Roebuck. & Co. College (1-4or 5+) Accountant-Bookkeeper permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If item 271s marked other the
any injury or other traumatic 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Hooper Mae Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8368 Gartelman Farm Drive, Millersville, Md. 21108 William Poteet 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Baltimore Cemetery 10/13/2004 * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A 237 E. Patapsco Ave., Baltimore, Md 21225-1856 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC COLON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ALTEMOSCIENTIC CARDIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown Completed DISFACE 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 2 No 1 🗍 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Phospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 21776 OCTOBER 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANOVER ST BACTIMORE 2625 SURLEAP- MUNDRA NU 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2004 Registrar

Wheeler, Olean

		1 - State Registrar				ertificate of	lealth and Death		Reg. No.	01 3260
Physici /Medic		1. Decedent's Nam			1>	Wheel		2. Date of D Month October	Pay 2	Year 945
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Funeral Director		5. Social Security I	-4697	. Sex 1 □ M 2√2 F	49 Yrs.	Months Days		(Month, D	22 55	9. Birthplace (State or For Country) SC
f show	tor	10a. State	10b. County		10c. City, Town or Balti					10d. Inside City Li
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or Items	by Funeral Director	11. Marital Status XXNever Mar	rried 2 Married	Armed For	dent Ever in U.S. 1: rces? XX No	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S can, Mexican, Puer	Specify Yes or N to Rican, etc.)	o- 14. Ra Bla Speci	ice - American Indian, ack, White, etc.
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Department of Healin Importent: If item 27 is any injury or other tre			sposition	☐Removal from S	State King Me	rematory or other pia ∋morial 22. Name and Addr	Park 10		1	to, Md 21 - City r Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death dent's Name (First, Middle, Last) Month Day Year **Physician** C50PM 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex **Funeral** 1 XM 2□ F Director NOHA 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director timor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Wence or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. λ 4 Divorced 3 Widowed 1 and 2 should be filed within 72 hours Health and Mental Hygiene. Pm 27 is marked other than "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7dary (0-12) College (1-4or 5+) 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/ Intionship (Type, Pri) Daughte . Mailing Address (Street and Number or Rural Soute Number, City or n. State. Zip Cod permit. Pages 1 and 2... Department of Health at Importent: If item 27 is eny injury or other treu once. lethod of Disposition 20b. Place of Disposition /N Surial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses freeze 23a. Part1. Enter the disease or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uch as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) SVI **Physician** Canies /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs 1 teams of it jury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the a detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? □ Yes 2□ No 24a. Was an page 2 has autopsy performed? certificate 20 o the Hospitel or Attending Physicien: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 Inter (Specify) P 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this hospile 28c. Injury at Work? 27 Manner I Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After atural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No death. after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13/2004 40854

State Registrar

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31. Date-tiled (Month, Pay, Year)

301

32. Registrar's Signature

19

Bultimore

21202

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mischer

		•	For State Registrar		State	of Maryla	and / Dep <i>Ce</i>		nt of H I <i>te of I</i>		d Me		giene Reg. No.	004	32611
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			Good Samarita 5. Social Security Num			7. Age (In v	rs. last birthday	1	ler 1 Year	If Under 24	Hrs. 8	. Date of Birt	h		tholace (State or Foreign
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Maryland	2 6 8 6		19a. Informant's Name Revena Deleo				19b. Mai 6206	ling Addre Ironwo	oss (Street a	and Number of Columbi	a MD	21045	r, City or T	Гоwп, State,	Zip Code)
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Baitimore,	permit. Pages. Department of H Important: If tte any injury or of once.		21. Signature of Fune	ral Service Licer	see Chri	stina L.	Hilton :	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	and Address d J. R larford	uck Inc. Road B	Baltir	nore Mar	yland	21214	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Me	29b. Signature and tit					1	29c. Licens					-	th, Dey, Year)
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	Sta Regist		31. Date liled (Month,	Day, Year)	100	Registrar's Si	ignature .	hoo							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 2004 Francis James Welsh 4c. County of Death 4b. City, Town, or Location of Death N/A 7. Age (In vrs. last birthday 1X M 2 T F

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12:20A /Medical Facility Name (If not institution, give street and number) **Examiner** Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 17, 1941 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 220 38 6039 Maryland Director 62 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2X No Anne Arundel Director Maryland Glen Burnie the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Marley Station Road 21060 U.S. or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White þ 3X Widowed 4 □ Divorced *naturat*, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 years School Teacher Public School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be William Welsh Lillian Tormollah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: if itam 27 Is any injury or other trai once. Bernard Welsh / Brother 402 Marley Station Road Glen Burnie, Maryland 21060 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ō 1 Burial 2X Cremation 3 Removal from State Bayview Crematory 10/12/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 ramuaulu 23a. Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Vital Records, P.O. Box 68760 attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month ó in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 PNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2010 Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funaral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and the of certifier 100,m

State Registrar 31. Date filed (Month Day, Year)

OCT 1 4 2004

82. Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wizbicki 10:30 A M Edward 2004 October 7 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore 3017 New York Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7/2/1942 Birthplace (State or Foreign Country) 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 215-40-2472 62 Director MD Usual Residence of Decedent with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other treumstic event, It is Medical Example at must be multipled at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Halethorpe 1 ☐ Yes 2 X No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3017 New York Avenue 21227 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Wizbicki Helen Piskonowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:s
Department of Health at
Important: If item 27 is
any injury or other treu Mrs. Patricia A. Wizbicki/wife 3017 New York Ave., Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State St. Stanislaus Cemetery 10/11/2004 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie N

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1 Second Ave SW Glen Burnie MD 21061 Approximate Interval Between Onsel and Death Immediate Cause (Final **Physician** 195cc uns disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗆 No 3 Probably 4 Unknown pluods Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy 1 Yes Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) delman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 4 2004

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Maryla				Mental Hygie	ne	00011
			Registrar 1. Decedent's Name (First, Middle, Last)		Cel	rtificate of	Death	Reg.	No.	3. Time of Death
ı	Physici		Dolores	Regina	lal c	bod		October	10,2004	
	/Medic Examir		4a. Facility Name (If not institution, give				or Location of Deat		4c. County of Deal	
			St. Joseph Medical	Center		Tows	on		Bali	timore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days		(Month, Day, Ye	9. Birt	hplace (State or Foreign untry)
	Director		213-80-1580 Usual Residence of Decedent	8	5 Yrs.			Oct.24,	1918 M	aryland
	/land		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Many a-f sh	tor	Maryland Balt	imore	Cocke	ysville	1			1 ☐ Yes 2 ☐XNo
	or 28g	Director	10e. Street and Number		000110	10f. Zip Code		10g.	Citizen of What Co	untry?
	23a c	al	10321 D Malcolm C	ircle		21030			U.S.A.	
	tems	Funeral		12. Was Decedent Ever in Armed Forces?		Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 【X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ X No	Specify:		Specify:	
Ö	be filed within 72 hours after death with the Maryland that Hygliene. Id other then "natural", or flems 23e or 28e-1 show event, the Madical Exertirer must be notified at		15. Decedent's Edu	cation	16a. Deced	ient's Usual Occup	pation	161	. Kind of Business/	11 te
215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wor	rking		
2	e filed within at Hygiene. I other then '	Con	88		Но	memaker			Own Home	<u> </u>
lud	be file d oth event	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Mai	den Sumame)	
yla	should be and Mental markad o	2		hein					lfe	
Maryland 21215-0036	ges 1 and 2 should it of Health and Mer If itam 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Ty)	•				ral Route Number, Ci		
ف	s 1 and 2 of Health a itam 27 Is other trau		Michael Wood 20a. Method of Disposition	Son 20b.	Place of Dispo	lybrook (sition (Name of		ltimore. N	lary land 2 Location - City or	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Di	u laney	Valley Valley al Garder	ce)			
===	nit. Parantinon ortant: injury:		21. Sign tup of Funetal Service License	90	Memori 22	al Garder . Name and Addre	ns IUTI	5-2004 <u>T</u> ick Towson	imonium,	Maryland
m	Depar Impol any ir		taul Office	: 6ha. —		1050 Yor	rk Road	Towson. M	laryland 2	21204
r			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	ations that caused the dea	ath. Do not ent	the mode of dyir	ng, such as cardiad		J	Approximate Interval Between
	Pitysician		Immediate Cause (Final disease or condition	Careha	_/ /	Eman	hoon			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	OF IOTT	ruge			2 hours
i.	Cxammer	_	Sequentially list conditions, b	Atherosclei	rotic C	andio	sascula.	~d15.845	0	
	ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
8760,	cate be executed physician and the burial-transit	dicalE			, , .					
68		0								
Вох	eath certif attending for use as	M/ul	230. Was decedent program	Bc. If yes, outcome of pregr		Ć			23d. Date of deli-	/ery
	ne deat the att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)	·		Month	Day Year
P.0	that the death	Physician/M	9 🗆 Unknown							
Ś	signed d be det	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	iderlying cause giv	en in Part I.		o use contribute to	
Record	w requir been si should	ompleted	Thonic Chan	uctive ru	mina	ry DIST	ease	1 🖳 Yes	2 □ No 3 □ Pro	bably 4 Unknown
3ec	ne faw has b	mple	Dementia					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
		0	Hypertensi	on				performed 1 Yes 2		2 No
Vital	ysician: is certific director.	o Be	25. Was case referred to medical examiner?	ospital:	In .	3 DOA Oth	00	th (Check only one)		
of	g Phys er this eral di	H- 1	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 ☐ DOA 28c. Injun Worl	4 Nuising H	ome 5 Residence 28d. Describe how in		ify)
0	Attending Ph er death. actor: After th by the funeral	atloi	1 ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No		,-,	
Division of	Attend ar death ractor: A by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (Street	and Number or Ru	al Route Number,
٥	rs after ral Dira	Cer		bounding, oto. (oppos	·· y /		1	City or Town, St.	4(0)	
	Hospi 4 hou Funar ely fill	ical	Check only 2 Medical Examin	er: On the basis of examin	owledge, death	occurred at the time	ne, date and place,	and due to the cause	(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after deals. To tha Funaral Director: After this certification and the funeral director. completely filled in by the funeral director.	Medical	29b. Signature and title of certifier	and manner stated.		29c. License				
	F & F &	_	200. Signature and title Certifel	11/		N 2	4110	29d. I	Date signed (Month,	In U
	.7	-	30 Name and Admin of annual	MS VIII	m 230) (T == '	UD'	7107		1 - 1/1	1-1
	10		/John [mpleted cause of-death (Ite	M) i	7600 Os	lend 12	210 TOW	Son, Ma	121264
	Sta Registra		31. Date filed (Month, Day, Year) OCT 1 4 200	32. Rigistrar's Sign	ature	Spark				

DHMH 16 Rev 6/95

Elmer Armiger 04-6428 AKG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

28	1	For Unpend Item 23a,27,28a-f per me - State of Maryland / Dep - State of Maryland / Dep - Registrar Ce	artment of Health and N C837 11-19-04 tas rtificate of Death		iene	00000
•	144	Decedent's Name (First, Middle, Last)		2. Date of Deat	th - U	3. Time of Death
Physiciar /Medica		Elmer Russell Armiger, Jr.		October	5, 2004	1:25 P M
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
		4112 Audrey Avenue	Baltimore	Table 1881		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 213-36-7470	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day April I	Year) 9. Bir	thplace (State or Foreign puntry) lryland
Director		Usual Residence of Decedent		Whiti I	0, 1541 M	itytana
yland	Ī	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
a-fst	2	MD Balti	more			1 X Yes 2 □ No
or 28a-f s	5	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?
ath w	0	4112 Audrey Ave.	21225		U.S.A.	
r Items 236	5	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whi	
Irs aft	ý	1 ☐ Never Married 2 ☐ Married 1 【XYes 2 ☐ No If Yes, Give Year or Dates:1959—1963	1 ☐ Yes 2 X No Specify:		Specify:	White
2 hot	2	15. Decedent's Education 16a. Dece	edent's Usual Occupation		16b. Kind of Business	/Industry
thin 7	2	Flementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	king	_	_
ed wi	Completed		abled		Unemploy	red
be fill d off	D D	17. Father's Name (First, Middle, Last)		ne (First, Middle, 1 or Edna	Maiden Sumame)	
d Mer narke	2	Elmer Russell Armiger, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rui			Zin Codo)
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Exert at art matter notified at once.	ï		Crosswind Dr.,		•	
Heal Heal tem S	-	20h Place of Disposition 20h Place of Disp	osition (Name of	Date	20c. Location - City or	
Pages ent of nt: If i	1	1 Burial 2 XCremation 3 XRemoval from State YORK to	matory or other place) wne n Service 200	4	York, P.	A 17404
mit. I partm sortei r inju	Ī		2. Name and Address of Facility J. Hartensteir	1	awii Tag	
Depar Impo any ir		/ Xariensian	24 Second St., N	New Fre	edom, PA	7349
-46	Ì	23a. Part Enter the disease, or complications that caused the death. Do not er shock, or hear failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arm	est,	Approximate Interval Between
Pnysician	1	Immediate Cause (Final diseas for condition a Head Injuries				Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):				
(= 3 = J.	5	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
		cause. Enter Underlying Cause (Ulsagae or injur)				
be executed ician and burial-transi	Examilia	that initiated events c. Due to (or as a consequence of):				
p cia	licai	d				
iii St	Ď.	IF FEMALE:				
eath certific attending p	any	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3	⊒Ectopic pregnancy		23d. Date of de Month	livery Day Year
by the a	Fnysicianim	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			,
that the detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
uires n sign lid be	o D			1 □ Y€	es 2 No 3 P	obably 4 Unknown
s been si should!	Completed			24a. Was a		utopsy findings available
The fav	Elo			autops perform	ned? death?	completion of cause of 2□ No
certificate ha	90	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only on		
S D	0	1 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	nt 3 DOA Other: 4 Nursing He	ome 5 Reside	ence 6 XOther (Spe	cihat scene
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Attending or death. ector: After by the fune	Icar	2 XAccident Investigation 10–05–2004 1:05	P ^M Thes 2 Kind		fell and st	
lor A after Direct	Certification:	4 Homicide determined determined building, etc. (Specify) Dwelling		City or Town	reet and Number or R. n. State)4112 Au e, Maryland	drey Ave.
spite nours nerel		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the ca	ause(s) and manner as	stated.
n 24 ł n 24 ł he Fu	edicai	(Check only one) Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occur	red at the time, d	ate and place, and due	to the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mont	h, Day, Year)
		Thoday M, life was	O.C.M.E.		October 6,	2004
		30. Name and address of person who completed cause adeath (Item 23a) (Type		D. 3		7 01025
		31. Date filed (Month, Day, Year) 32. Registrar's Signatuse	111 Penn Street,	Baltimo	ore, Maryla	ind 21201
State Registra		OCT 1 4 2004	ports			

Reg DHMH 17 Rev 1/2001

			. 101	artment of Health and Me	ental Hygie Reg.	2001	32617
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Bessie Marie Albaugh	\$	Month September	Day Year 28,2004	6:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	
			Frederick Memorial Hospital	Frederick		Frederic	k
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign
	Director		209-24-1638 1□ M 2⊠F 87 Yrs.	World's Day's Hours Will.			land
	and W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Aaryli sho	ō					1 ☑ Yes 2 ☐ No
	28a-1	Director	Maryland Frederick Fre	derick 10f. Zip Code	100	Citizen of What Co	untn/2
	with the or		1900 Rosemont Avenue	21702			
	ns 23	era				United St 14. Race - Amer	
မွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other traumatic event, "he Medical Evartina must be routified at ODGE.	Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White	e, etc.
<u></u>	rel', c	l by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite
20	72 hc	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working	165	. Kind of Business/l	ndustry
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ž	d Mer narke	٦	Noah Beeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		Bennet		
Ma	d 2 sl th and 7 ls r traur		The state of the s	ing Address <i>(Street and Number or Rural</i> L Placid Lake Terrac			20074
ė,	1 an Heell em 2		20a Method of Disposition 20b. Place of Disp	osition (Name of	ite 20c	ntown, Ma Location - City or 1	
<u>o</u>	ages int of t: If it		1 ⊠Burial 2 □Cremation 3 □Removal from State cemetery, cre	matory or other place) Octob	er l,	odsboro,	
Baltimore, Maryland 21215-0036	ertme ortan injur			Cemetery 20 2. Name and Address of Facility Star			
B	Depermine Depermine Impo		1 QQ 16	621 Opossumtown Pik	e Freder	rick Mar	s, r.A. vland 21702
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			rick, nar	Approximate
	Pnysician			HEART EATHURI	-		Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	HEART FAILURE			0101147
Ė	Examiner		Sequentially list conditions, b. COROWARY ANT	ERY RABEASE		5	9mounts
	D #	ner	fl any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and trans	Examiner	that initiated events c.				
8760,	cate be executed physician and the burial-transit	ai E	Due to (or as a consequence of):				
87	physi the l	dicai	d				
9 X	that the death certific ed by the attending p detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	
Вох	atter I for u	ciar	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month Month	Day Year
P.O.	the d y the	iysi	1 Yes 2 No 9 Unknown				
	res that igned b be deta	y Pi	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
Vital Records,	- v T	Completed by Physician/Me	DEGENERATIVE ARTHRIDES		1 🗌 Yes	2 (No 3 Pro	bably 4 Unknown
S	aw requis been 2 should	plet			24a. Was an	24b. Were aut	opsy findings available
Ä	The lavate has bage 2	HO:			autopsy performed	? death?	ompletion of cause of
ita	ysicien: The lar is certificate has director, page 2	Be C	25. Was case referred to medical examiner?	26. Place of Death (^		
<u>†</u>	hysic his ce I dire	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3□ DOA Other: 4□ Nursing Home	e 5 Residence	6 Other (Spec	ify)
ū	ing P	on:	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	d. Describe how in	njury occurred	
sio	tend leath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
Division of	or At after of Dirac in by	Certification;	determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town, St	' and Number or Rui 'ate)	ai Houte Number,
	pital curs a lerel filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place, an	nd due to the cause	a(s) and manner as	stated
	24 hos 24 hos 9 Fun etely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date	and place, and due	to the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month	Day, Year)
}			More P. Howell lind	D46075	(3/28/00	ye.
			30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)			
	200		Mary P. Howell, M.D. 65 Thomas John	nson Drive Frederi	ck, Maryl	land 21702	2
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 3 0 2004	1			
	Registr	ar	SET SU COUR PLANT	9 Sparks			

			For State Registrar		State of	Marylan		artmen rtificat			and M		Reg. No.		32518
	Physici /Medic	\ \	1. Decedent's Nam	e (First, Middle, La ELIZABE		OLD						2. Date of De Month Sept.	Day 29 2	2004	3. Time of Death 9:10 p ^M
	Examin			If not institution, giv rumsco Ro		oer)				Location o			_	nty of Death erset	
	Funeral Director		5. Social Security N 219-30-3 Usual Residence o	994	Sex 7 1 □ M 2 💁 F	. Age (In yrs.	last birthday) 58 Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bi (Month, Da Oct. 3	th ay, Year) 1935		olece (State or Foreign ntry) yland
	Aaryland f show	ō	10a. State	10b. County Somerset	_		y, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-	Director	10e. Street and Nu			122	2011 200	10f. Zip					10g. Citizen	of Whal Cour	ntry?
	s 23a	rai		rumsco Ro			2 10		838			7 1	USA		
920	172 hours atter death with the Maryland *natural*, or Items 23a or 28a-f show refinal Examinant has be notified at	by Funerai	11. Marital Status 1 Never Marr 3 Widowed	ried 2 [™] Married 4 □ Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? ☑No		Was Deced If Yes, spec	cify Cuban	Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		lace - Americ Black, White, cify: whi	etc.
21215-0036		Completed	Elementary/Seco	15. Decedent's E cify only highest gra ondary (0-12)		lor 5+)	(Give life.	dent's Usua kind of wo DO NOT us	rk done di se retired)	urina most	of working	ng		Business/In	
d 21	e filed within all Hygiene. other than vent, Ita Ma	e Cor	17. Father's Name	(First, Middle, Last)		Techi	nicia		18. Mothe	r's Name	(First, Middle	Food S , Maiden Sum		3
Maryland		To Be		Neat	Tura Delan		405 14-77			Anna	a	Freib	ertaus	er	
Mai	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic			ame/Relationship (Arnold (h									er, City or Tow cation,		
	is 1 and 1 a		20a. Method of Dis	position		20b. F	Place of Dispo					ate	20c. Locatio		
Baltimore,	Pages ment of l ant: If Its ury or o			☐ Cremation 3 ☐ 5 ☐ Other (Special			bwridge				0/4/	2004	Elkrid	dge, Ma	aryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fu	uneral Service Lice	Doun	1							Home, F e City,		1851
	Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	on	plications that can one cause on each	ised the deat th line.	h. Do not en	AN	, -		cardiac o	r respiratory a		non	Approximate Interval Between Onset and Death
8760,	Examine be executed physician and purial-transit sithe burial-transit	dical Examiner	Sequentially list or if any, leading to ir cause. Enter under Cause (Disease or that initiated event resulting in death)	s injury	b	r as a conseq	uence of):								
P.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?		h 2 ☐ Fete nt at time of d	Ideath 3	Ectopic pr						Date of delive	ery Day Year
	sign sign d be	ğ	Part II. Other signi	ficant conditions	contributing to dea	th but not res	ulting in the u	nderlying c	ause giver	n in Part I.			obacco use co Yes 2 □ No		ne cause of death?
I Records,	The ate h	Completed								-		24a. Was auto perfo	osy ormed?	D. Were auto prior to cor death? 1 \(\sum \text{Yes}	psy findings available mpletion of cause of
Vital	Physician: Th rithis certiticate ral director, pag	Be	25. Was case reference examiner?		Hospital:				Other			(Check only			
of	Attending Physic death. ector: After this by the funeral di	tion; To	1 ☐ Yes 2. ☐ 27. Manner of Dear 1. ☐ Natural 2 ☐ Accident	th 5 ☐ Pending investigatio	28a. Date of (Month,		28b. Time o Injury		28c. Injury Work	4 🗀 1901	2		dence 6 C how injury occ		1)
Division	i He o	Certification;	3 Suicide 4 Homicide	6 Could not be determined	286. Place 0	f Injury - At h	ome, farm, str	reet, factory	/, office		2	8f. Location (City or To		mber or Rura	l Route Number,
	ne Hospital 24 hours a ne Funeral i	edical (29a. Certifier (Check only one)	1 ☐ Certifying Pl 2 ☐ Medical Exam	nysician: To the b miner: On the bas and manne	is of examina	owledge, deat ition and/or in	h occurred vestigation	at the time , in my opi	e, date and nion, deat	d place, a h occurre	nd due to the	cause(s) and i date and place	manner as st e, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and	title of certifier	M)		290	c. License		3,3		29d. Date sign		Dey, Year)
	. H. 4		30. Name and add	ress of person who	completed cause	of death (Item	n 23a) (Туре,	Print)	00 0	Eren	lins	2 Cle	10/1	ld; in	410
	Sta Registr		31. Date filed (Mor	OCT 0 1	2004 32.	gistrar's Signa	ture	mode	,					100	21817

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Paul Eugene AUSHERMAN October 4, 2004 6:30 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Clearview Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 25, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F 84 Yrs. Maryland 217-18-7871 Director Usual Residence of Decedent worde I 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or iteme 23e or 28e-f ehovine Madical Examiner must be notified at 1 X Yes 2 ☐ No Directo Marvland Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 475 Pangborn Boulevard 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 2 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) assembler - machinist trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be it. Pages 1 and 2 should be furthent of Heelth end Mental I want; if Item 27 is marked o Harry Edger Ausherman Bertha Whitacre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Myers - daughter 60 Williamson Ave., Greencastle, Pa. 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/04 Hagerstown, Maryland 4 Donation 5 Other (Specify) Rose Hill Cemetery permit.
Depertu
Imports
eny Infu 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME red Liv esta 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Fibrilla tron **Physician** Atrial /Medical Due to (or as a consequence of): Examiner Maksonn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien end s the burlei-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No P.O. NA 9 Unknown NIA 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 1 Yes 2 No 2**X** No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funerel director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred Injury at Work?

1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide NIA Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 0058181 3H.8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTORM MD 2746 PEPRAH 382 S. CLEVELAND AUE KODUAH 31. Date filed (Month, Day, Year) 32. A gistrar's Signature State OCT 0 5 2004 Registrar

	For Stete Registrar	State of Maryla		ertificate of L		Mental Hygien	2001	32620
Physician	Decedent's Name (First, Midd	(le, Last)				2. Date of Death	ay Year	3. Time of Death
/Medical Examiner	4 50 100 kg 44 44 45 45 45	on, give street and number)		4b. City, Town, or	Location of Death	September 4	26, 200 c. County of Dea	
Funeral	11412 Tall Fore 5. Social Security Number 214-76-5506		s. last birthday Yrs.	Germanto If Under 1 Year Months Days	Wn If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	ontgomer	thptace (State or Foreign buntry)
Director	Usual Residence of Decedent 10a. State 10b. Count		City, Town or L	conting		Nov. 15,	1919 Tur	
with the Marylan s or 28a-1 show be notified at			rmantov					10d. Inside City Limits 1 ☐ Yes 2X No
23s or 28a-1s	10e. Street and Number 11412 Tall Fore	est Circle		10f. Zip Code 20876			itizen of What Co	ountry?
or items	3 ☐ Widowed 4 ☐ Divorced	tf Yes. Give	U.S. 13.	. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- PRican, etc.)	14. Race - Ame Black, Whit Specify: Wh:	
within 72 ho	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or 5+)	(Giv	edent's Usual Occupa e kind of work done d DO NOT use retired,	urina most of work	sing 16b.	Kind of Business/	Industry
Hiled will Hygien other the ent. It is ent.	17 Fatharia Nama /First Afidella	, Last)	Ta	ailor	18. Mother's Nam	e (First, Middle, Maide	othing	
d Mental narked o	Omer	ohio (Timo Print)	10h Mail	line Address (Carea a	Zulfiye	of Boats March 2012	T 0	
Depermit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat, any injury or other traumatic event. It a Marical Ex. any injury or other traumatic event. It a Marical Ex. any injury or other traumatic event. It a Marical Ex. and Item 27 is Marical Ex.	19a. Informant's Name/Relation Reha Ayalp/Sor 20a. Method of Disposition XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	1 20b.	11412 Place of Disp cemetery, cre		est Circ			20876
Departm Departm Importa any inju	21. Signature of Funeral Service		2	22. Name and Addres	s of FacilityHine	es-RInaldi	F.H.	ng, MD 2090
Shysician physician and physician and physician and the pniral-transit the pniral-transit dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardiany Due to (or as a conse b. Coronary Due to (or as a conse c. High Cho Due to (or as a conse d.	equence of): Artery equence of): lestero					Interval Between Onset and Death
ate has been signed by the attending phy page 2 should be detached for use as the Completed by Physician/Medi		23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
s been signed by should be deta	Part II. Other significant conditi	ions contributing to death but not re	esulting in the I	underlying cause give	n in Part I.	23e. Did tobacco		the cause of death?
certificate has been s irector, page 2 should						24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
this certification and director	examiner? 1 ☐ Yes ※ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie		r: 4 ☐ Nursing Ho	me 5 X Residence	6 □Other (Spec	cify)
the rospinal of Attenting Privaling 2 hours after death. 24 hours after death. pletely filled in by the funeral digital digital of the funeral digital digital of the funeral digital of the funeral digital of the funeral digital of the funeral digital of the funeral digital of the funeral digital of the funeral digital of the funeral digital of the funeral digital of the funeral digital	27. Manner of Death 1X Natural 5 □ Pendi 2 □ Accident invest 3 □ Suicide 6 □ Could	igation on the	28b. Time of Injury	Work M 1□Y	? les 2 \Bo	28d. Describe how inju		
I to the hospital of Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. Medical Certification: To Be C	77	nined 286. Place of Injury - At building, etc. (Spec	cify)			28f. Location (Street a City or Town, State	e)	
in 24 hou the Fune ipletely fil	one)	ng Physicien: To the best of my kr I Exeminer: On the basis of examinand manner stated.	nowtedge, dea nation and/or ir	th occurred at the time nvestigation, in my op	e, date and place, inion, death occurr	and due to the cause(s red at the time, date an) and manner as d place, and due	stated. to the cause(s)
within 2 To the complet	29b. Signature and title of certified			29c. License			ate signed (Month	n, Day, Year)
3	30. Name and address of person	who completed cause of death (Ite Fallic 1400 Fo:		, Print)		ring, MD		
State Registrar	31. Date filed (Month, Day, Year,) 32. Registrar's Sign	nature	Ann V.		<u> </u>		

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month EDWIN M. BECKER SEPTEMBER 30 2004 6:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **SALISBURY** WICOMICO WICOMICO NURSING HOME 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 211-16-9692 79 7/1/1925 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 10050 Golf Course RD USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2**X** No Specify: White þ 3 ☐ Widowed 4 ☐ ivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Scientific filed within Hygiene Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Importent: If item 27 is merked other that any injury or other traumatic according. 4 Owner Equipment Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Becker Helen Monteith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10050 Golf Course RD Ocean City, MD 21842 Cheryl Thrift Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/30704 1 Burial 2 X Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory Frankford, DE 22. Name and Address of Facilithe Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St. Berlin, MD derson 110284 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANDIOVASCULAR DISEASE THEROSCIENOTIC /Medical Due to (or as a consequence of): **Examiner** PULMONARY 0 EMBOUSM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) The law requires that the death certificate be executed Exam and Due to (or as a consequence of): physicien a s the burial-Physiclan/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live hirth 2 Deetal death 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been sig GIASTROINTESTINAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy performed? 1 ☐ Yes 2 No page certificate 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 5 Pending To the need by the funder of t 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-0060515 Mululul MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
614 EASTERNSHORE DR SALISBURY ND 21804 MAHESHA THIMMARAYAPPA M.D. 31. Date filed (Month, Day, Year) 32. gistrar's Signature

State

Registrar

OCT 0 1 2004

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar MEND FTEM #20b PER FH G836 10/14/04 JH Certificate of Death 2. Date of Death Month **Physician** Alfred William Cloud, Sr. Hember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Levindale Hospital **Baltimore** Baltimore City If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. **X** M 2□ F Yrs Director 156 20 9204 76 March 5,1928 New Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral, or Itama 23a or 28a-f shov Examinar must be potified at 1 Yes 2 No Director Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Cloud Lane 21901 **United States** Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X es 2 No 1948— 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. Iam 27 Is markad othar than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced 1951 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 12 Owner/Operator Cloud Electric Electrical Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James L Cloud Alice Magnier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred W Cloud, Jr./Son 50 Coud Lane, North East, Maryland 21901 20b. Place of Disposition (Name of 20a. Method of Disposition OCT 20c. Location - City or Town, State Pages 1 nent of H ant: If its 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Petersburg, New Jersey Petersburg Methodist Cemetery permit. Page Department of Important: If any injury or once. uneral Service See 22. Name and Address of Facility Crouch Funeral Home 21. Signatur 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Athero sc /Medical Due to (or as a consequence of): **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes No 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Death the funeral 28c. Injury at Work? (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide o the Hospital or within 24 hours a To the Funaral I 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number

qu

Debra Wertheimer, 2434 West Belvedere Street, Baltimore, Maryland 21215 31. Date filed (Month, Day, Year)

2376

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William wo

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	R	leg. No.() ()	11 0	2001
Physician		2. Date of Dea	th C	Voor	Time of Death
/Medical	Aurelia Casso		9/2004		9:02pm
Examiner	Washington Adventist Hospital 4b. City, Town, or Loc Takoma		4c. County o	f Deeth Lgome 1	сy
Funeral Director	5. Social Security Number 579-64-8776 6. Sex 1 M 2 F 7. Age (In yrs. lest birthday) 1 If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth 12-12-	1 ⁹ 13 1	9. Birthplace Country) DOMIN	State or Forei
D .	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location				
with the Maryle to 28a-f show the motified at Director	MD 10b. County 10c. City, Town or Location Silver Spring	g		_	side City Limi EYes 2□N
23a or 2 unit be no	10e. Street end Number 11443 Lockwood Dr #A4 20904	1	0g. Citizen of Wi		
permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. Important: if item 27 is marked other than "satural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified at page. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Never Married 4 □ Divorced 1 □ Never Married 5 □ Married 1 □ Never Married 2 □ Married 1 □ Yes ★ ★ ★ Yes 2 □ No Dominic Call		Black,	American In- White, etc. Black	
r2 ho	15. Decedent's Education 16e. Decedent's Usual Occupation		16b. Kind of Busi		
iene. than "r the Med	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Yrs (Give kind of work done during most of working life. DO NOT use retired) Teacher	ng	Educa	ation	
tal Hyg d other event, Be C	17. Fether's Neme (First, Middle, Lest) 18. Mother's Name	(First, Middle, I	Maiden Surname)	1	
Mental Mental Merked arric ev	Antonio Geronimo Luci	ia Gar	cia		
should North	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number	, City or Town, S	tate, Zip Code))
alth e 27 is	Iris Benlizar(Daughter) 11443 Lockwood Dr				
of He ifem other	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - C		
Page nant:	Maryland Nat 1 9-2	24-04	Laurel	Md	
oartm Sorta / Inju	21. Signature of Funeral Service Locases 22. Name and Address of Facility			-	
P P P P P	Sterling E	Tunera.	l Servi	.ce	
	POB 617 Sterling N 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	/a 201	6.7	Anne	oximate
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Stroke			Inter	val Between et and Death
je je	Due to (or es a consequence of): Aspiration Pneumonia			į	
icate be axecuted physician and s the burial-trensit	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): Atrial Fibrillation C. Due to (or as a consequence of):			1	
a a a	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):				
at the death ce d by the attend stached for us: Physiclan/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	bacco use contr	bute to the o	ause of deat
as that the de igned by tha a be datached to by Physic					4 🗆 Unkno
aw requir is been s 2 should pieted		24a. Was ar perform		available	on of cause
cata ha		1 □ Ye	s ŽŪNo	1 🗆 Yes	2 🙀 №
ysician: In sentificata director, pa	25. Was case referred to medical examiner?	(Check only one	9)		
	1 ☐ Yes XXNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home			(Specify)	
After th funeral	Naturel 5 Pending (Month, Day Year) Injury Work?	3d. Describe ho	w injury occurred		
rs effer death. al Director: After teled in by the funer. Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Str. City or Town	reet and Number , State)	or Rural Rout	e Number,
Hospi 24 hou Funer Itely fill	29a. Certifier (Check only one) 29a Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, an and manner stated.	nd due to the ca d at the time, da	use(s) and mann ite and place, and	er as stated. I due to the c	ause(s)
vithin 2 To the compla	29b. Signature and title of certifier 29c. License number		d. Date signed (/		
8 4 8 4	AMI +			-	oai)
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)		Sept 20,	ZUU4	
	Mark Li 1721 University Blvd Wheaton Md 20	902			
State Registrar	31. Date filed (Month, Day, Year) OCT 1 4 2004 32. Degistrer's Signature				

			1 - For Stete Registrar	State o	of Marylan		rtment of H	lealth and M Death		giene Reg. No.	A Contract	32624
	Physic	an	Decedent's Name (First, Midd	lle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	/Medi		Betty	L.		Carle			Sept.	21, 200	04	11:45 AM
	Examir	ner	4a. Facility Name (If not institution		imber)	İ		Location of Death		4c. Count	of Death	
_			14546 Carleto 5. Social Security Number	n Lane 6. Sex	7. Age (In yrs. I	a a d Sieth et al.	If Under 1 Year	den If Under 24 Hrs.	0.0-1(8)	Som	erset	
8	Funeral Director		215-26-4151 Usual Residence of Decedent	1□M 2 X F	74	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 08-30-1	y, Year)		lace (State or Foreign try) 71and
	anyland show	_	10a. State 10b. County	/	10c. City	, Town or Lo	cation				10	0d. Inside City Limits
	Ba-f.	Director		erset		Eder	1					1 XYes 2 □ No
	ith th	Die	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
	s 23s	ia i	14546 Carleto			-	21822			USA		
36	y within 72 hours after death with the Maryland jiene. r then "naturel", or items 23a or 28a-f show the Medical Examiner rund be notified at	by Funeral	Narital Status Never Married 2 ☐ Mar Widowed 4 ☐ Divorced	rned 1 ☐ Yes	No No	II	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (Spi n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e	etc.
3	hour turel			Year or D	vares:	163 Doggd	ent's Usual Occupa	ation		10h Kind of B	Whi	
215-0036	in 72 "na	Completed	(Specify only highe	est grade completed)		(Give)	kind of work done of NOT use retired	ation du <i>ring m</i> ost of work:)	ing	16b. Kind of B	usiness/Ind	ustry
7		mo mo	Elementary/Secondary (0-12)	College (1-4or 5+)		okkeeper	•		Acco	untin	10
0	Hyg othe	a)	17. Father's Name (First, Middle,	Last)			J. W. Spel	18. Mother's Name	e (First, Middle,			-Б
yland	Q to D S	0.0	Robert Owens,	Sr.				Marie El	len Rua	rk		
_	should ind Men is marke umatic	_	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rura	al Route Numbe	r, City or Town,	State, Zip	Code)
e, Ma	D = F =		Bonnie Davenpo	rt/Daught	er 20h Pi	5066	Cooper R	oad, Eden	MD 21	822 20c. Location	Ciby as Tay	Chair
galtimore,	permit. Pages 1 an Department of Heal importent: If Item 2 any injury or other once.		1 ☐ Burial 2 ★ Cremation 4 ☐ Donation 5 ☐ Other (5	3 □Removal from Specify)	State	metery, crem	crematory or other place	θ)			•	Maryland
g	permit Depart import eny inj		1. Signature of Funeral Policy	Licensee	1,,,,,,,,			s of Facility eral Home				N.T. 01050
	3000		23a. Part1. Enter the disease, o shock, or heart failure. List		M00295 caused the death	. Do not ente	or the mode of dying	rset Aven g, such as cardiac c	or respiratory an	ncess A rest,		Approximate
	Physician		Immediate Cause (Final	only one cause on e	each line.		_		_			Interval Between Onset and Death
H	/Medical		disease or condition resulting in death)	a. Due to	(or as a consequ	ence of):	enic 0	batruct	IVE TO	MONTE	> Dis	>20 yrs
	Examiner		Ge. JOHN THOUSENING WY		(5. 20 2 0000qb	31.00 31).				,		/
Ц		Jer	f any, leading to immediate	Due to	(or as a consequ	ence of):						
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Š	an ar	Ж	resulting in death) Last	Due to	(or as a consequ	ence of):						
9/60	icate be executed physician and s the burial-transit	dical		d.								
O	certifica oding ph		IF FEMALE:									
.O. BOX	The law requires that the death certifule has been signed by the attending cage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live b	tcome of pregnar birth 2 Fetal nant at time of de own	death 3	Ectopic pregnancy Other (specify)				te of deliver onth (y Day Year
	s that ned t	by Pi	Part II. Other significant conditi	ons contributing to d	eath but not resu	lting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?
cords,	quire n sig utd bh		HR	IAL FIBR	ZILLAY	NON	Hyp	FRIENS	ON 1/2/9	es 2 No	3 🗌 Proba	ibiy 4 Unknown
000	s bee	lete		/) 7.		24a. Was a	n 24b.	Were auton	sy findings available
al Le	raicien: The law s certificate has t lirector, page 2 s	Completed							autop: perfor	sy med?	prior to com death? 1 🗌 Yes 2	pletion of cause of
Vital	siciel	Be	25. Was case referred to medica examiner?	Hospital:		-120	Othe	26. Place of Death				
ō	Phys r this ral di	. To	Yes 2 No 27. Manner of Death	28a. Date		R/Outpatient 28b. Time of	3☐ DOA 28c. Injury	4 Nursing Hor				
SION	ding h. After fune	tlon	Vatural 5 ☐ Pendir	ng (Mon	th, Day Year)	Injury	Work	ai ? ′es 2 □ No	28d. Describe h	ow injury occuri	ea	
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2	after i Dire	Certification:	4 Homicide determ	buildi	ng, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	or, ractory, ornos	4	City or Town	n, State)	er or nural :	noute Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edicai C	one) Z Medical	ng Physician: To the Examiner: On the b and man	asis of examinati	on and/or invi	estigation, in my op	inion, death occurre	ed at the time, d	late and place, :	and due to t	the cause(s)
	To th within Fo the	Me	29b. Signature and title of certifie	%×			29c. License	number	2	9d. Date signer	d (Month, D	ay, Year)
			1 - Bull	1 wy			D3	5576		9/23/	04	
			30. Name address of person	who completed caus	e of death (Item	23a) (Type, F	Print)			/	50	
			RONALD	P	RAUCT	~ A	UD 56	O RIVE	ersion	= DR	Sa	links MC
	Sta	ite	31. Date filed (Month, Day, Year)	32. R	legis r's Signati	ıre				_		
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/B.B '3."	ian	1- Stata Registrer AMEND ITEM #20a PER FH G836 1. Decedent's Name (First, Middle, Last) Catherine Luers Duvall	O/14/67 On same	2. Date of Death Sept.	g. No. 290 24 200	3. Time of Death 4 800 a M
/Medic Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 94 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Bin Ma	hplace (State or Foreig unitry) ryland
the Maryianu 28a-f show	rector	10a. State Maryland Anne Arundel 10c. City, Town or Leading Annapolise 10c. Street and Number		10	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 □ No
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Filem 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avent, the Medical Examble of intel to indiffed at	Funeral Director	1009 Moss Haven Court 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	21403 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ι	Jnited Sta 14. Race - Ame Black, White	tes
within 72 hours ene. than "natural", he Medical Exel	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece (Give life. 16b. 16c. 1	I Yes 2 No Specify: Ident's Usual Occupation Is kind of work done during most of work DO NOT use retired) acher	ing	Specify: Will Sb. Kind of Business/	Industry
snould be titled withing the marked other than imarked other than immatic avent, the marked other than immatic avent, the marked in the marked	To Be Co	17. Father's Name (First, Middle, Last) William Luers	18. Mother's Name	ite Micke	aiden Sumame)	
permit. Pages 1 and 2 sic Department of Health and Important: If item 27 is ma any injury or other traums		Mareen Duval1/ son 1006 20a. Method of Disposition 1 Burial X Cremation 3 Removal from State	matory or other place)	napolis,	MD 21403 Oc. Location - City or	
permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Jo 47 Duke of Glouces			al Hom e , I MD 21401
Madical De executed by Addical Parallel Addical Parallel Addical Parallel Addical Parallel Addical Parallel Addical Parallel Addical Parallel Addical Parallel Parallel Addical Paralle	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ration Pheumon,		,	Approximate Interval Between Onset/and Death OLCLY S
in the death certifically by the attending phase tached for use as the	Physiclan/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deli	very Day Year
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	e Completed	25. Was case referred to medical		24a. Was an autopsy performe	prior to o death?	opsy findings available ompletion of cause of
this certific	Certification: To Bo	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide Homicide 1 Nospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury At home, farm, str building, etc. (Specify)	f 28c. Injury at Work? M 1 Yes 2 No	ne 5 Residence 28d. Describe how	et and Number or Rui	,,
death.		29a. Certifier 1 to Certifying Physician: To the best of my knowledge, death	h occurred at the time, date and place, a	and due to the caus	se(s) and manner as	stated.
death.		(Check only 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurre			to the cause(s)
iffer death. Sirector: After in by the fune	Medical	2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier 20b. Signature and title of certifier 20b. Signature and address of person who completed cause of death (Item 23a) (Type Bouland Bouland Death (Item 23a) (Type Bouland Bouland Death (Item 23a) (Type Bouland Bouland Death (Item 23a) (Type Bouland Bouland Death (Item 23a) (Type Bouland Bouland Death (Item 23a) (Type Bouland Bouland Death (Item 23a) (Type Bouland Bouland Death (Item 23a) (Type Bouland Death (29c. License number D 4 6 6 7 2	29d	. Date signed (Month, 9 2 4 0 4	Day, Year)

DHMH 17 Rev 1/2001

				State of Ma	aryland	-	rtment of F tificate of		Mental Hygi Re	ene g. No. () ()	14 32	626
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Death Month			Time of Death
	Physici /Medio		Alice Elizabeth D	ennis					September			20 p.m.
-	Examir		4a Facility Name (If not institution, give	e street and number)				4b. City, Town, or L		4c. County		
Ĺ			Northampton Manor				If Under 1 Veer	Frederic		Fre	ederick	24-1
	Funeral Director		214-46-5693		e (in yrs. ias)4	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, January	Year) 15, 19	Country) 10 Mary	State or Foreign Land
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				10d. ln	side City Limits
	f sho	ō	Frederick Freder	ick	Fre	deric	k				13	☐Yes 2☐No
	288s	rect	10e. Street and Number				10f. Zip Code		10	g. Citizen of \	What Country?	
	3a of		907 Pontiac Av	enue			217	01		.U.S.	A .	
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Mental Hyglene. Important: if item 27 is marked other then "netursi", or items 23a or 28s-f show simportant: if item 27 is marked other then "netursi", or items 23a or 28s-f show althy injury or other traumatic event, the Modical Examines must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cub	Hispenic Origin? (Sj an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		e - American Ind ck, White, etc. /: Wh	_{dian,} nite
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give k	ent's Usual Occup	during most of wor.		6b. Kind of B	usiness/Industry	
121	ithin Jen Mar	Completed	Elementary/Secondary (0-12)	College (1-4or 5			O NOT use retire	d)		Oven	home	
2	Hygiel Hygiel Her ti	S	10 17. Father's Name (First, Middle, Last)			Homem	aker	18. Mother's Nan	ne (First, Middle, M			
and	d be f ntail the	Be	David Ausherman						Summers			
Maryland	should be f and Mental is marked of umatic eve	P	19a, Informant's Name/Relationship (Type, Print)		19b. Mailing	g Address (Street	and Number or Ru	ral Route Number,	City or Town,	State, Zip Code)
	end 2 sauth er n 27 is		Elizabeth Dorsey		r	8502	Laddie	Court, Wa	lkersvil	le, Ma	ryland 2	21793
Baltimore,	Pages 1 en ont of Hear int: If Item irry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content of the conten	Removal from State	20b. Plac		sition (Name of matory or other pla t Cemete		Date 2 9/29/2004		City or Town, Serick, N	_{tate} Maryland
i i	permit. F Depertme Importan eny injur		21. Signature of Funeral Service Licer		0	22.	Name and Addre	ess of Facility St	auffer F	uneral	Home	
ä	Deper Impol eny ir		Mayou lan	10. /	Dina.	116	21 Oposs	umtown Pi	ike, Fred	erick,	Marylar	nd 21702
			3a. I art1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.						Appr	oximate val Between
J	Physician		Shock, or neart failure. List only	one cause on each in	110.						Onse	et and Death
7	/Medical		Immediate Cause (Final disease or condition	CONG	2571	UE	HEAR	1 PAIL	una		Mo	N945
	Examiner		resulting in death)	a	Due to (or a	s a consequ	uence of):				1	
	sit sit	ine		b								
	ificete be executed g physician end as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or a	is a consequ	uence of):				į	
68760,	be ey ician burie	E E	cause. Enter Underlying Cause (Disease or injury	c								
587	phys s the	edicai	that initiated events resulting in death) Last		Due to (or a	s a consequ	ience of):					
Box (certif nding use a	M		d								
	atter d for u	icia	Part II. Other significant conditions o	ontributing to death h	ut not resulti	ing in the un	derlying cause di	ven in Part I.	23b. Did tot	acco use co	ntribute to the	ause of death?
P.O.	the c	hys	Part II. Other significant conditions of	onthibuting to doubt b	at not room.		donying added g		1 □ Ye	s 2 No	3 Probably	4 Unknown
	that ned l	y P										
cord	The law require, that the death certified has been signed by the attending page 2 should be detached for use a	Completed by Physician/M					·		24a. Was an		available	topsy findings prior to ion of cause ?
Re	ne iav e has age 2	E C							1L Y	2 2 1 No	1 ☐ Yes	2□ No
ta	sicien: The law certificete has t lirector, page 2 s	Be C	25. Was case referred to medical	-14				26. Place of Dea	ath (Check only one)		
<u>></u>	Physicien: r this certific and director,	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 El	R/Outpatient	t 3□ DOA Ot	her: 4 Nursing H	ome 5 Reside	nce 6 □Oth	er (Specify)	
on of	ding Phy th. After this funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		8b. Time of Injury	28c. Inju Wo M 1		28d. Describe ho			
Division of Vital Records,	To the Hospital or Attending Physicien: within 24 hours efter death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not b determined	200. Flace of Inj	jury - At hom c. (Specify)	e, farm, stre	et, factory, office		28f. Location (Str City or Town,	eet and Numb State)	per or Rural Rou	te Number,
	To the Hospital within 24 hours To the Funerel completely filled	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysiclan: To the best niner: On the basis of and manner st	f examinatio	edge, death n end/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and ma te and place,	anner as stated. and due to the o	ause(s)
	o the omple	Me	29b. Signature and title of	///		_	29c. Licen			_	d (Month, Day,	Year)
	- 5 - 0		> /bll	an-			12	6499		9-28	8-04	
			30. Name and address of person who	completed cause of c	death (Item 2	(Type, F	Print)					
			Ronald E. Miller					e, Mt. Ai	ry, Maryl	and 2	1771	
	Sta Registi		nd Date filed (Month Day Vocal)		rar's Signatu	ге	B 4	souls				

LAURA LEE DAECH 04-06406 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Unpend Item Registrar	State of Maryland 23a&27 per me	d / Depa G836ექ	artment of H Pitileate of t	lealth and Beath	Mental Hy	giene Reg. No.	001.	00007			
			Decedent's Name (First, Middle, La.					2. Date of De	ath	 	3. Time of Death			
	Physici /Medi		Laura	Lee Dard	ch			Month OCTOBE	$\stackrel{Day}{R}$	2004	1:00P. M			
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Dea	th	4c.	County of Death				
5			5482 HALLOWING PT			PRINCE FI				ALVERT				
1	Funeral		5. Social Security Number 6. S	□ M aXIE	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Da			place (State or Foreign htry)			
7	Director		225-80-5608 Usual Residence of Decedent	51				Jan 19	, 195	3 Wash	., D.C.			
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation		-		1	0d. Inside City Limits			
	a-fs	ctor	MD Ca	alvert]	Prince Fr	ederick				1 ☐ Yes 2 🙀 No			
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Coul	ntry?			
	death with the Maryland ms 23a or 28a-f show		5482 Hallowing 1			206				USA				
	er de Items	Funerai	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (: .n, Mexican, Pue	Specify Yes or No nto Rican, etc.)	- 1	 Race - Americ Black, White, 				
36	irs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			Specify: whi	to			
ŏ	72 hours after natural', or ite		15. Decedent's Ed	ducation	16a. Deced	lent's Usual Occupa	ation		16b. Kir	nd of Business/In				
215	thin 7 e	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of OO NOT use retired	during most of wo	nking						
21	ed wi	Co		2	reg	istered n	urse		hea	ealth care				
Maryland 21215-0036	be fill Hall Had off	Be	17. Father's Name (First, Middle, Last)					me (First, Middle	Maiden	Sumame)				
<u> </u>	nould d Mer narke natic	10	Joseph Allison 19a. Informant's Name/Relationship (Leapley	405.44.75	A11 (8)	Lila	Mae	Le					
Ma	d 2 sl th an th an traur	6	Steven K. Darch	туре, Рппі)		ig Address (Street a					20070			
စ်	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, Itam Medical Examiner must be notified a page.		20a. Method of Disposition		ace of Dispo	Hallowin sition (Name of		Rd., Pr		Frederic cation - City or To				
Baltimore,	ages ent of st: If I		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif	Memovai from State	-	natory or other plac	1	0 0 04	7	2000	100			
量	artm. Fortar		'4 □ Donation 5 □ Other (Specify) Hillcrest Mem. Cemetery 10-8-04 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility											
ä	Deparmi Departimpo any in		* William 21	Sam	F	Rausch Fu	neral Ho	me, P.A.	- Ow	inas. M	20736			
	-		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between			
	Enysician		Immediate Cause (Final disease or condition	Atheroscler	otic (Cardiovas	cular Di	sease			Onset and Death			
7	/Medical Examiner		resulting in death)	Due to (or as a consequ										
- 1	Examiner	_	Sequentially list conditions,	b										
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	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):									
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9	Ξ On α													
Вох	res that the death certifi igned by the attending I be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23	3d. Date of delive	•			
	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	ath 5	Other (specify)				Month	Day Year			
P.0	The law requires that the tite has been signed by the bage 2 should be detache		Part II. Other significant conditions of	ontributing to death but not resu	Iting in the ur	derhina cauca ana	on in Part I	23a Did t	phaceo ite	e contributo to th	e cause of death?			
ds,	signe d be	d by	Tax III all all all all all all all all all	ormouning to double but not rose	mig in the di	identying dadae give	erini ranti.				ably 4 Anknown			
So	w requir been si should	ete												
Rec	rician: The tav certificate has rector, page 2	Completed						24a. Was autor perfo		prior to cor death?	osy findings available npletion of cause of			
ta	ificate or. pa		25. Was case referred to medical				OC Diseased De	1 Xes ath (Check only o	2 🗆 No	1. Yes	2 No			
>	Physician: this certifical	To Be	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ E		Othe		dome 5 Resid		X Other (Specifi	SCENE			
9	ig Physiter this control direction		27. Manner of Death		28b. Time of Injury	28c. Injury Work	at	28d. Describe h			CERT			
io	andin sath. or: Af	atic	1 Natural 5 Pending 2 Accident investigation	1	Mary		res 2 □ No							
Division of Vital Records,	or Att ter de irect	Certification;	3 Suicide 6 Could not be determined		me, farm, stre)	eet, factory, office		28f. Location (5 City or Tox	Street and m, State)	Number or Rura	Route Number,			
٥	oltal c urs af aral D							1						
	To the Hospital or Attanding Physician: The l within 24 hours after death. To the Funaral Director: Atter this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exan	ysicien: To the best of my knowniner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)			
_	Fo the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	signed (Month, I	Day, Year)			
			De anell			o.c.	M.E.	0	CTOBI	ER 5,200	4			
			30. Name and address of person who		23a) (Type,									
				NB10, MD		11 Penn S	Street,	Baltimor	e, Ma	aryland	21201			
	Sta Registr		31. Date filed (Month, Day, Year)	7 2004 Signat		1								
	Registr	वा	0010	1 LUUTI DERLA	, 5	pule								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER 23, DRATLER ISABEL Μ. 2004 4:00 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death MARINER HEALTH AT CIRCLE MANOR MONTGOLERY KENSINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□ F 1938 WASHINGTON, DC 66 APRIL 6, Director 577-52-7803 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event. It e Madical Examiner trust be notified at Director 1√ Yes 2 No MARYLAND MONTGOMERY KENSINGTON 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? or Items 23a 10231 CARROLL PLACE 20895 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after of Hygiene.
Hygiene. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ♥ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Importent: ## Item 27 is marked other any injury or other treumatic event. ## 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS MARKWOOD SHIRLEY MANDELL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SISTER 4620 N. PARK AVENUE, #908E CHEVY CHASE, MD 20815 JULIET N. SLAVIN, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) WASHINGTON HEBREW CONG CEM. 9/28/2004 WASHINGTON, DC 21. Signature of Fun al Service 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the dispase, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failfred. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician PNEUMONIA /Medical Due to (or as a consequence of) Examiner DIABETES INSIPITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy The law requires that the death ö in the past 12 months? Month Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 ☐ Yes 2 💢 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 X No this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospitei within 24 hours a To the Funerei D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

2

DHMH 17 Rev 1/2001

Registrar

DOOS

BETHESDA, MD

25/04

ou, up

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRUONG BAO, M.D., 5622 SHIELDS DRIVE,

SEP 29 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 20000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 **Physician** 2004 09 4:10 PM Dykes Robert /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Salisbury Wicomico wicomico Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 08-20-1918 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 M 2□ F Maryland Director 171-10-2510 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f ehow eny injury or other treumatic event, the Medical Examination matter to invitified. 1XYes 2 □ No Directo Delmar Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8481 Engle Drive 21875 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Engineer Electrical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lorena Noel Dykes Emerson Theodore Dykes ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8481 Engle Drive, Delmar, MD 21875 Linda Alder/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 09-27-2004 West Post Office, MD Friendship U.M. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fungal Service Licensee 22 Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, 21853 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final DEPSIS Physician resulting in death) /Medical Due to (or as e consequence of): Examiner NIFECTION URINARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): sicion and burial-transit death certificate be executed Exami Due to (or as a consequence of): Physician/Medical attending phys use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) been signed by the should be detached 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DISEASE 24a. Was an autopsy page 1 ☐ Yes 2 No certificate ATHEROSCIEROTIC 1 Yes 2 No DISTACT ANDIOVASCULAK or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes > No Medical Certification; To 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by t 4 Homicide filled 1 🖔 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D-0160515 Munin

State

Registrar

2121

Maryland

Baltimore,

P.O. I

Records.

Vital

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Division

BEASTERN SHINE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 3 0 2004

32. Registrar's Signature

M. TitlMMAAA YBTH
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year HELEN MARIE DUMAIS 8:25 A M 9 29 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17 Moonshell Dr. Ocean Pines Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2X F Director 557-52-5670 Washington, DC 67 4/15/1937 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "neturet", or ttems 23e or 28e-f show other treumatic event, the Medical Examinar must be recitived at 10d. Inside City Limits Director 1 Yes 2 No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 17 Moonshell Dr. 21811 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H 7 is marked ot Be Joseph Gerald Dempsey Mary Alice Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Richard Dumais 710 Chapel Ridge RD Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ites
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 10/2/04 Berlin, MD 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St. Berlin, MD 23d. Part1. Enter the disease, or complications that caused the teach. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Non Insulin Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to or as a consequence of The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 ☐ Yes 2 ☐ No 1 Tes 2 X No Hospitel or Attending Physicien: Be 25. Was case referred to medical director 26. Place of Death (Check only one examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ٢ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour⊾ the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46257 9/29/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar SEP 3 0 2004

Edwin Castaneda, MD 10324 Old Ocean City Blvd. Berlin, MD 21811

				State of Mary	land / Dep	artment of I	Health and M		9.0	0	0.000		
			AMEND TIEM #23b, 258 T. Decedent's Name (First, Middle, Last)	26 per phy	8830 4e		D eall1	2. Date of Dea	teg. No./		3. Time of Death		
	Physici /Medi		Theresa, E	vaus				Month	27	Year	45A.W		
)	Examir		4a. Facility Name (If not institution, give				4b. City, Town, or Lo		4c. County	of Death	[3/] ./		
			Clinton Nursing			(dinton	Prince Georges					
	Funeral Director		040343634	7. Age (Ir Тм 2)х F 7. Age (Ir	yrs. last birthday Yrs.	If Under 1 Year Months Days		8. Date of Birtl (Month, Day		9. Birthplace Country) South	(State or Foreign Carolina		
	laryfand show		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d.	Inside City Limits		
	the Man 28a-f sh criffed	Director	Maryland St. Mar	ry's	Leonardt						1 ☐ Yes 2 🛣 No		
	with Ba or	ρ		Count Amon		10f. Zip Code	0		10g. Citizen of	-	<i>!</i>		
	death	Funeral	22680 Cedar Lane (2. Was Decedent Ever			U Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	U.S.A	• ce - American	Indian,		
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the same 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 No		Rican, etc.)	Bla Specif	ck, White, etc. y: White			
2-0	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	pation during most of worki	ina	16b. Kind of B				
121	within ane.	mp	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worki			1.0			
d 2	filed v Hygie other 1		12 17. Father's Name (First, Middle, Last)		St	ipply Cle	Y	Federal Government er's Name (First, Middle, Maiden Surname)					
Maryland	12 should be filed within h and Mental Hygiene. r is marked other than " traumatic event, the Mer	To Be	Herman Holley				Inez Sa	alters		,			
lary	should had and had some	_	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mail	ing Address (Street	t and Number or Rura	al Route Number	r, City or Town,	State, Zip Co.	de)		
	Health Health tem 27 I		Mal Utleye / Perso				ayflower I						
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Re		Ob. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or Town,	State		
Him	# 본뿐 등		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ★ icense			eld-Echo		/1/04	Charlo	tte Hal	1, MD		
Ba	Depa Impol any Ir		The Mark	1		2. Name and Addre	Bri Lywood Rd.	nsfield , Leona					
			25a. Fart1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the e cause on each line.						Ap	proximate erval Between		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	Car	dio ce	pealer	feel	lee) On	set and Death		
	Examine	į.	resulting in death) a	Due	to (or es e conse	quence of):		· ·					
	uted d ansit	Examiner	Constitution and Ministra		E RENAL, to (or as a conse	DISEASE/S	SEPSIS						
oʻ	ificate be executed g physician and as the bural-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200	to (or as a conse	querice or/.							
68760,	ate be hysici the bu	edical	that initiated events resulting in death) Last	Due	to (or as a consec	quence of):							
	± σ α α	an/Me	d.										
Вох	feath certi attending of for use	iclan	Dort II. Other circuitions and disconnection	olleration to death but a	A (b) (A)								
P.0	at the de by the a stached	Physica	Part II. Other significant conditions cont	nouting to death but no	t resulting in the u	nderlying cause giv	ren in Part I.		pecco use com es 2□ No	4	ceuse of death? y 4 □ Unknown		
	es tha igned be de	þ									,		
Vital Records,	s law requires that the death cen has been signed by the attendin pe 2 should be detached for use	Completed						24a. Was a perform	n autopsy ned?	availab	utopsy findings le prior to tion of cause n?		
<u>=</u>	Page 1	Соп						1⊜76	s 214Nu	t⊡Ye	s zu No		
Vita	Physician: This certifica	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Coath				100000		
ō	hys this aldi	2 12	1 ☐ Yes X☐ No 27. Manner of Death	28a. Late of Injury	2 ER/Outpatier 28b. Time o	it 3LI DOA	A Trursing Hon	5 ☐ Reside 8d. Describe ho					
on	Attending or death. Botor: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury	Wor	k? Yes 2 □ No		,a.y oooa				
Division	l or Atter after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (St	At home, farm, str pecify)	eet, factory, office	2	8f. Location (Sti City or Town	reet and Numb , State)	er or Rural Ro	ute Number,		
_	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)	cien: To the best of my er: On the basis of exar and manner stated.	knowledge, death	n occurred at the tin vestigation, in my o	ne, date end place, e pinion, death occurre	nd due to the ca d at the time, da	use(s) and ma ite and place, a	nner as stated and due to the	cause(s)		
	To the within 2 To the comple	¥ E	29b. Signature and title of certifier	and marrier stated.		29c. License	e number	29	d. Date signed	(Month, Day,	Yeer)		
			Human	Paspuli	MD	D60	1999		8/3	31/04			
			30. Name end address of person who con	PASPUL	A MI); (06	IRVIN	IG ST	wa	is hier	ptouDe		
	Sta Registra		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar's S	ignature	bouts							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 24, 2004 **Physician** 3:58 P M Faber Rose Caro1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 15211 Elkridge Way, #2K Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec 16, 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Yrs. 183-20-3638 75 Illinois Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If them 27 is marked other than "natural", or Items 23e or 28e-f show may july or othe traumatic event, the Modical Eventhal must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 → No Maryland | Montgomery Directo Silver Spring 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 20906 15211 Elkridge Way, #2K United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Senator 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samue 1 A. Cooper Rebecca **Pollin** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15211 Elkridge Way, #2K Morton C. Faber, husband Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns. 9/27/2004 Olney, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22 Name and Address of Facility
Edward Sagel Funeral Direction, Inc. Donald. ottlemuer 1091 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatio ~ Cancer **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 21 No 9 ☐ Unknown 9☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Hesidence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 26,2004 D43202 Leterre work BIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3305 North Blankfard MD C. Ozanne Mary land 20006 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 29

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year TROY GLOVER /Medical OCT 2004 11:45 4 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days Hours Yrs. Director 078-58-7261 43 Sept. 1961 New York Usual Residence of Decedent tha Maryland 10a, State 10b. County 10c. City. Town or Location Show 10d. Inside City Limits 7] Is marked other than "neturel", or frams 23a or 28a-f shot traumatic evant, tre Medical Examinar must be notified at Director 1 ☐ Yes 2 XNo VA Prince William Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3424 B Quarters 22134 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1♥DYes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ba filed within 72 hours after dal Hygiene. dother than "neturel", or Itam Black, White, etc. 1 Never Married 2000 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 27 No þ Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 4 Education Counselor U.S. Marine Corps permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is markad ofth eny liquy or other traumatic event, SINB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eldin Glover Claire Carrathers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie E. Glover - Wife 3424 B Quarters Quantico, VA. 22134 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National 10/13/04 Quantico, VA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Covenant Funeral Service CC0336 Fredericksburg, VA. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician B/T CELL LYMPHOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit requires that the death certificate ba exacuted Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 ☐ Yes 2 录 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death e Hospitel or Attending P 24 hours after death. e Funerel Director: After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 🌋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Defining rhysidal. To the best of my knowledge, seath occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number - mn 0101236858 (VA) ,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER COREY A. CARTER LTUSNR MC BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar The to but I have

4-06284 essica Gelatka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Maryland 1 - State Registrar		tificate of L			leg. No.	39691.			
	D		Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death			
	Physicia /Medic	al	Jessica Rachel Gelatka				Septemb	er 29, 20				
	Examin	er	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital			Location of Death Frederick	ζ.	4c. County of Calv				
	Funeral Director		5. Social Security Number 195–66–1094 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last) 17	st birthday) Yrs.	Months Davs Hours Min. (Month, Day, Year) Country)							
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits			
	Mary e-fah	tor	MD Calvert County Pri	ince I	rederick				1 □ Yes 2 No			
	with the	Funeral Director	10e. Street and Number 1721 Clay Hammond Road		10f. Zip Code 20678			10g. Citizen of Wha				
	death ms 23	eral	11 Marital Status 12. Was Decedent Ever in U.S.	. 13. \		ispanic Origin? (Spanic Origin? (Spanic Origin)	ecify Yes or No-	14. Race -	American Indian, White, etc.			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28e-f ahow any Injury or other traumatic event, it a Medical Examiner must be neitling an once.	by Fur	Amed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	1 □ Yes 2 ▼No If Yes, Give 1		Specify:	nicali, etc.)	Specify:	White			
2-0	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	lent's Usual Occupa kind of work done of DO NOT use retired	ation during most of works f)	ing	16b. Kind of Busin	ess/Industry			
72	iene. iene. rthan	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)			e Student		High Sch	nool			
D	al Hyg I other vent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Sumame)				
<u>ya</u>	ould b Menta	70	William L. Gelatka				n Laure		To Code			
Mar	d 2 sh sh and 7 is rr traum							r, City or Town, Sta Frederick	x, MD 20678			
	Heall tem 2 other		20a. Method of Disposition 20b. Place	ce of Dispo	sition (Name of matory or other place		Date	20c. Location - Cit				
E	Page: nent o int: if iry or		1 Burial 2 Ocremation 3 Hemoval from State	Crem				Clinton,	Maryland			
Baltimore,	permit. Departr Imports any Inju		21. Signature of Fund a Service Licenses	22	2. Name and Addres				alvert, P.A. s, MD 20736			
			23a. Part1. Enter the disease, or complications that caused the death.						Approximate Interval Between			
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conseque	Inv	iries				Onset and Death			
	/Medical Examiner		resulting in death) Due to (or as a conseque	ence of):								
	Examine:	er	Sequentially list conditions, if any, leading to immediate Due to (or as a conseque	ance of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.									
Ö,	tificate be executed 19 physician and as the burial-transit		resulting in death) Last Due to (or as a conseque	ence of):								
68760,	physic properties	edical	d									
.O. Box (The law requires that the death certifute has been signed by the attending tage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ■ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Date o Month	f dølivery Day Year			
<u>α</u>	s that t ned by e detai	by Ph	Part II. Dther significant conditions contributing to death but not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?			
ords	w require been sig should b						101	res 2/2 No 3[☐ Probably 4 ☐ Unknown			
I Records,	The law rate has be page 2 shu	Completed					24a. Was autop perio 1 Yes	rmed? prio	re autopsy findings available r to completion of cause of th? Yes 2 No			
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		oth Oth	26. Place of Deat						
of	Phys r this ral dir	- To	27. Manner of Death 28a. Date of Injury 2	R/Outpatier 28b. Time o	IL 3LI DOA	4 Nulsing no		dence 6 □Other (now injury occurred	Specify) Driver of a			
on	Attending Phyrdeath. ector: After thi	atlon	1 Natural 5 Pending (Month, Day Year)	2:40 F		k? Yes 2.XNo			ved in a collision			
Division	l or Attendater deat	ertification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	Roadi			28f. Location (S City or Tox Beach	m, State) Derse	or Rural Route Number, 14 Rd at Daves			
_	Hospital Hours Luneral ely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know and manner stated.	dedge deat	h occurred at the tir	me, date and place, opinion, death occur	and due to the	cause(s) and mann	er as stated. I due to the cause(s)			
	To the within 2 to the I complet	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (f	Month, Day, Year)			
•			· Carol Hallan md			O.C.M.E.	9	September	30, 2004			
	5		30. Name and address of person who completed cause of death (Item : CAROLH . ALLAN MA	111	Penn Str		rimore,	Maryland	21201			
::	St Regist	ate rar	31. Date filed (Month, Day Year) 32. Registre Signatu	, K	Speck	•						

DHMH 17 Rev 1/2001

		1	For State Registrar	State of M	laryland		rtment tificate				F	Reg. No	004	32635
	Physicia		Decedent's Name (First, Middle	, Last) Donald Leo	Craan						2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution,				4b. City, To	own, or L	ocation o	f Death	Deplem		2/ 2004 County of Death	1.2
	Examin	er	Washington Coun				Hage	rsto	wn			1	Washingt	
	Funeral Director		5. Social Security Number 219–34–5294	6. Sex 7. A	ge (In yrs. Ia:	st birthday) Yrs.	If Under 1 Months	Year Days	Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Jan.	h y, Υθατ) 6, 1	9. Birthp Cour 938 Man	lace (State or Foreign htry) yland
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show f must be notified at	ţō	Maryland Fred	lerick	M	yersv:	ille							1 □ Yes 2√010No
	th the	Sirec	10e. Street and Number				10f. Zip C						en of What Cour	
	s 23s	rail	2041 Canada Hill	L Road	t Ever in 11 S	13	2177		United Sta					
	be filed within 72 hours after death with the Marylan deliyedies. A property of other than "natural", or items 23a or 28a-f show event, the Medical Eracinet must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	Armed Forces	:?]No								Black, White, Specify: whit	etc.
2-0036	72 hou	ted	15. Decedent (Specify only highes	's Education	1,01	16a Dece	dent's Usual kind of work DO NOT use	Occupat done du	tion uring most	t of workir	ng	16b. Kin	d of Business/In	dustry
2	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)				3			E1.00	trical H	Outor
7 0	filed w Hygie other ti	CO	11. 17. Father's Name (First, Middle,	Last)			Linema		18. Mothe	r's Name	(First, Middle,			Ower
<u>a</u>	Aental rked o	To Be	Russell J. Gree	en							. Smith			
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relations Jeffrey A. Green								<i>l Route Numbe</i> Myersvi		Town, State, Zip	
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Mt. Zion U.M. Cemetery 9/30/04 Myersville											
Ĕ	Pages tment of tant: if it		`4 ☐ Donation 5 ☐ Other (S	pecify)	Mt.				-				sville,	
Bal	permit Depar Impor any in	22. Name and Address of Facility P.O. Box 136 Ricketts Funeral Home Myersville,										MD 21773		
	Physician		Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caus only one cause on each	ed the death.	,	ter the mode		0 1		r respiratory a		isease	Approximate Interval Between Onset and Death
ı	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ence of):								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequ	ence of):								
760,	eath certificate be executed attending physician and for use as the burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or a	as a consequ	ence of):								
687	ificate g phys as the			d										
.O. Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								3d. Date of deliv Month	ery Day Year		
s, P	luires that the signed by all do detact		Part II. Other significant condition	ons contributing to death	but not resu	Ilting in the I	underlying ca	iuse give	n in Part I	l.		tobacco us		he cause of death?
Record	yalcian: The law requir is certificate has been si director, page 2 should	Completed									24a. Was auto perfo		death?	opsy findings available impletion of cause of
Vital	ician: Th certificate ector, pag	Bec	25. Was case referred to medica examiner?	Hospital:				Cthe	ar:		(Check only			
of/	Phyalcian: this certific ral director,	٠ <u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗀 Inba		ER/Outpatie 28b. Time		A Cthe Bc. Injury Work	4 🗀 N		me 5 Resi 28d. Describe		G □Other (Speci y occurred	fy)
	ding h. After fune	tion	1 ☑Natural 5 ☐ Pendii	28a. Date of J ng (Month, igation	Day Year)	Injury	М		<br Yes 2 □	No				
Division	i or Attendi after death. Diractor: A d in by the fu	ertification;	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace UI	Injury - At ho etc. (Specify	me, farm, s	treet, factory,	, office				(Street and wn, State)		al Route Number,
	To the Hospital or Attenwithin 24 hours after deat Within 24 hours after deat To the Funeral Diractor: completely filled in by the	edicai C	29a. Certifier Cartifyin (Check only one) 2 Medical	ng Physician: To the be Examiner: On the base and manner	s of examinat	wledge, dea ion and/or i	th occurred a nvestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) , date and	and manner as s place, and due t	stated. o the cause(s)
}	To the within 2 To the complet	Me	29b. Signature and title of certific	illent	m, D.C	FAI	29c.	License 440	88	4		29d. Date	e signed (Month,	Day, Year)
	6		30. Name and address of person	who completed cause of	of death (Item	23a) (Type	, Print). Lieta	m_/	St.	1+	1. md	2	1740	
	St Regist	ate rar	31. Date filed (Month, Day, Year	32. Reg	istrar's Signa	ture	4	An	2 1	,	1			
			001	U J LUUT			- /	-07-0						

DHMH 17 Rev 1/2001

			1 - State Registrar	e of Maryla		artment of I rtificate of	Health and N Death	-	giene Reg. No.: 004	32636
		93	Decedent's Name (First, Middle, Last)					2. Date of De.	ath	3. Time of Death
	Physicia /Medic		FRANCES G	REEN				Month SEPTEMB	ER 24, 200	8.4
	Examin		4a. Fecility Name (If not institution, give street and	d number)		4b. City, Town, o	or Location of Death		4c. County of De	
	+		HEBREW HOME OF GREATER			ROCKVILI			MONTGOME	RY
B	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 💆		rs. last birthday) 89 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 10/27/1	9. B y, Year) (nthplace (State or Foreign Country) AND
7			Usual Residence of Decedent					10/2//1	.914 POI	AND
Z a	how	_	10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
W	Be-fa	cto	MARYLAND MONTGOMERY	RO	CKVILLE					1 X Yes 2 No
£	or 2	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
tt	23	erai	6105 MONTROSE ROAD	Decedent Ever in	alle to	20852	Hispania Osining (Co	and Van as No	U.S.A. 14. Race - An	andon Indian
5	ltem ltem	Ľn.	Ame	d Forces? 'es 2 📉 No		If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
036	cals are cean with the way a rel', or Items 23s or 28s-f sho Exeminer must be notified at	by	If Yes	, Give or Dates:		1☐Yes 2X No	Specify:		Specify:	WHITE
21215-0036	natur.	Completed	15. Decedent's Education (Specify only highest grade comple	tad)		dent's Usual Occup	pation during most of work	rina	16b. Kind of Busines	s/Industry
72	iene. r than "natu he Medical	mpie	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	life.	DO NOT use retire	d)	9		
2 2	tygie ther th		12 17. Father's Name (First, Middle, Last)		CASH	IER	19 Mothor's Nam	o /First Middle	FOOD Maiden Sumame)	
Maryland	and Montal Hygiene and Martine roots are locative minimum maryand and Montal Hygiene lismarked other than "naturel", or items 23s or 28s-f show aumstic event, the Medical Examiner must be notified at) Be						e (rirst, Millione,		
Z should	mark mati	2	BAER PANSTER 19a. Informant's Name/Relationship (Type, Print,		19b. Mailir	ng Address (Street	RACHEL and Number or Run	al Route Numbe	WHITMA or, City or Town, State,	
Z 2	27 is		MARTIN GREEN/HUSBAND						MD 20853	
ore,	# # # # # # # # # # # # # # # # # # #		20a. Method of Disposition	1	D. Place of Dispo	and the second s		Date	20c. Location - City o	r Town, State
imic	Int: H		1 X Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)				TERY 09/26	/2004	CAPITOL HE	IGHTS. MD
Baltimore,	permit. Toges I are a subura to be perment of Health and Menta important: If Item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licensee	, .	22	2. Name and Addre	ss of Facility	SACRES INVALLED		
111 8	10539		- Umander / Yua	lug	<u>_</u>	170 RUCKV	TLLE PIKE	, KUCKV	ILLE, MD 2	0852
		5	23a. Pert1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the door each line.	eath. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	MET	4 STATI	ic BRF	TIN CF	tnc El	2	6 WEEKS
	/Medical xaminer		Dui	to (or as a cons	sequence of):					
	12 p	ē		e to (or as a cons	sequence of):					
beta	dansit	Examiner	Cause (Disease or injury that initiated events							
o,	an an rial-tr			to (or as a cons	sequence of):					
\$8760, leate be executed	physician and the burial-transit	dlcai	d							
() ×			IF FEMALE:	outcome of pre	ga a a a a	7.000				
2 8 8 . Box 6	attending for use as	lan	in the past 12 months?	, outcome of pre- ive birth 2 □ F regnant at time o	etal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	olivery Day Year
V 0 8	0 0	Physician/Me		nknown	N CHAIN 5	Other (specify)				
R.O. 9	igned by be detac	by Pr	Part II. Other significant conditions contributing	to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	o the cause of death?
rds	gis un		PARKINSON'S	DISE	ASE			1 □ Y	es 2 5 No 3 □ F	robably 4 Unknown
CES Records,	s been s 2 should	piet	HYPERTE	NSION				24a. Was		utopsy findings available
	ate has page 2	Completed						autop perfor 1 ☐ Yes	med? death?	completion of cause of
/ita	certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Deatl	n (Check only or	ne)	
A A Not Not Not Not Not Not Not Not Not Not	his I di	5			ER/Outpatien		4/ jursing Ho		ence 6 □Other (Spe	ecify)
	h. After th funeral	Certification:	1 Natural 5 □ Pending	ate of Injury Month, Day Year	28b. Time of Injury	Wor	ryat rk? Yes 2∐No	28d. Describe h	ow injury occurred	
Division	tor: the	fica	3 Suicide 6 Could not be	lace of Injury - A	I home, farm, str	reet, factory, office		28f. Location (S	treet and Number or F	ural Route Number.
Di Di	ours after oneral Directilled in by	Serti	4 Homicide	uilding, etc. (Spe	ecify)	,		City or Tow	n, State)	
Div	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		29a. Certifier (Check only 2 Medical Examiner: On the	the best of my l	knowledge, death	h occurred at the tir	me, date and place,	and due to the c	ause(s) and manner a	s stated.
ŝ	ii t	ledicai	one) and	nanner stated.						
٩	To corr	Σ	29b. Signature and title of certifier	. 10		29c. Licens			29d. Date signed (Mon	
	2			<i>m</i> n	1		081		SCT- 2	+ 2004
			30. Name and address of person who completed	cause of death (I		MONTR	INSE DO	Racki	ILLE MI	20852
	Sta	te		2. Registrar's Sig		/	0-0 09	- UCF-V	7	-002
	Registra		SFP 29 2004	Depur	v B	Spark	2			

		For	State of Mar	yland / Dep	artment of H	ealth and	•	-		
		1 = State Registrar		Ce	rtificate of L	Death	Reg	. No.	32637	
° Physici	an	Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Year	3. Time of Death	
/Medi		Helen H. Harri	ngton				October			
* Examir	er	4a. Facility Name (If not institution,			4b. City, Town, or	Location of Deat	h	4c. County of Dee	th	
		5816-D Jefferson			Frederi			Frederi		
Funeral		5. Social Security Number 212-50-9698	6. Sex 7. Age (1 1	'In yrs. last birthday) QQ Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Day, Y	9. Bir	thplece (State or Foreign ountry)	
Director	ļ	Usual Residence of Decedent		88 Yrs.			May 25,	1916	Maryland	
yland	-	10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits	
Mar a-f st	ţ	Maryland Frede	rick	Frederi	ck				1 Yes 2 No	
th the	Director	10e. Street and Number			10f. Zip Code		109	Citizen of What Co	puntry?	
be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Medical Examination intelligible.		5816-D Jefferson	n Pike		21703			U.S.A.		
r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whit		
s afte	by FL	1 ☐ Never Married 2 ☐ Marrie	ed 1 ☐ Yes 2 χ No If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:	,,	Specify:	White	
hour: lural		3 XWidowed 4 □ Divorced	Year or Dates:							
within 72 ene. than nation	Completed	15. Decedent (Specify only highes		(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	urina most of wor	rking 16	ib. Kind of Business/	Industry	
withii than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	1,70.	Teacher			Elementar	r Cabool	
d 2 should be filed within 72 hours af this and Manatel Hygiens 17 is marked other than "natural; or traumatic event, I'm Medical Exam.		17. Father's Name (First, Middle, L				18. Mother's Nar	ne (First, Middle, Ma		y SCHOOL	
ould be Mental arked o	To Be	Claude	Hargett				halene Dot			
2 should be and Mental is marked raumatic ev	-	19a. Informant's Name/Relationsh	-	19b. Maili			ral Route Number, C		in Code)	
		Robert C. Harri	ngton, Jr.				Frederic			
t He item		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place			c. Location - City or		
permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			et Cemete:	· 1	1/2004 E-	والمناء أوما	V1	
permit. Departm Importa any inju	1	21. Signature of Funeral Service L			2. Name and Address	The second secon	1/2004 FI	ederick,	Church Street	
permi Depa Impo any ir		P. Keran	Mª Millian	> Ke	enev and Bas	sford P.A.	Fimeral Hon		k, MD, 21701	
		23a. Part1. Enter the disease, or can shock, or heart failure. List of	complications that caused the						Approximate	
Physician		Immediate Cause (Final							Interval Between Onset and Death	
/Medical		disease or condition resulting in death)	a. ASCVD Due to (or as a c	onsequence of):					Years	
Examiner										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unide lying Cause (Disease or injury	Due to (or as a c	onsequence of):						
te be executed ysician and le burial-transit	Examiner	that initiated events	c							
e exe		resulting in death) Last	Due to (or as a c	onsequence of):						
	ical		d							
ortificat ing phy	Med	IF FEMALE:						1		
death certificat e attending phy id for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date of deli		
	SICI	1 ☐ Yes 2 ☑ No	4 Pregnant at tim 9 Unknown		Other (specify)			Month	Day Year	
at the d by the letache	Phy	9 Unknown								
requires that een signed b		Part II. Other significant condition	is contributing to death but h	not resulting in the ui	nderlying cause giver	n in Part I.	1	co use contribute to		
w require been sig should b	ted		<u> </u>				1 L Yes	2 L No 3 L Pro	bably 4 Vunknown	
10 to 10	Completed						24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of	
Th ate pag	S						performed 1 ☐ Yes 2 😿	d? death?	2 □ No	
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	W- 24				th (Check only one)			
Physician: this certific ral director,	၉	1 X Yes 2 □ No		2 ER/Outpatien		4 🗆 Nursing 🗖	ome 5 🏋 Residence	e 6 □Other (Spec	rfy)	
ling After une	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending		ear) 28b. Time of Injury	Work?		28d. Describe how i	injury occurred		
of or Attending after death. I Director: After d in by the fune	icat	2 Accident investiga 3 Suicide 6 Could no	at bo	A15.		es 2□No			_	
5 ± ± -	i i	4 Homicide determin	28e. Place of Injury building, etc. (8	- At nome, farm, str Specify)	eet, factory, office		28f. Location (Stree City or Town, S	it and Number or Rui State)	ral Route Number,	
To the Hospital within 24 hours at To the Funeral D completely filled i		29a. Certifier 1☐ Certifying	Physicians To the heat of a	nu kanuladan dant		1				
24 hc Fun stely	edicai	(Check only 2 Medical E	Physician: To the best of m xaminer: On the basis of ex and manner stated	amination and/or inv	vestigation, in my opii	nion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To the I within 2 To the I complet	Me	29b. Signature and title of certifier	A A		29c. License	number	29d.	Date signed (Month	Dev Year)	
⊬≯⊢ŏ		> (Innel	11 71	WP						
		30. Name and address of person w	the completed on the doct	(Item 22a) (Ton-	D35164		00	tober 8,	2004	
		Andrew Zarick,				Frederi	ck Marul	and 2170	1_4501	
Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature 🎤	#	TEGETT	ca, naryl	anu, ZI/U.	L-4JUI	
Registr		OCT 1 & 20	84 Brown	1	Acres 1					

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other treumatic event, Ita Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar		Cei	rtificate of L	Death		Re	g. No.)	101	00000		
	Decedent's Name (First, Middle, Last)						2. Date of Death Month	Ca Co	Year	3. Time of Death		
an al	HILLIS ALVIS H	AWKINS					OCTOBER	Day 11.	Year 2004	8:00 PM		
er	4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or	Location o	f Death		4c. Cou	nty of Death			
H	1604 STRAND AVENU 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	WESTMINSTER CARROLL birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthple								
		^{M 2} XX 91	Yrs.	Months Days	Hours	Min.	OCTOBER	31,19	12 NO	place (State or Foreign ntry) RTH CAROLINA		
	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits		
ctor	MARYLAND CARROLL		WESTMI	NSTER		1 □ Yes 2 □ YN						
ai Dire	10e. Street and Number 1604 STRAND AVENUE			10f. Zip Code 21157			10g. Citizen of What Country? UNITED STATES					
Be Completed by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 200No If Yes, Give Year or Dates:	.S. 13.	can Indian, etc.								
mpiete	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give life. I	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most	of workii	ng 1		Business/In	ndustry		
Ŝ	17. Father's Name (First, Middle, Last)		П	OMEMAKER	40.14-4-	de ble :	(F) 1 14 (1) 14		ESTIC			
							(First, Middle, M	aiden Sum	iame)			
2	EDWIN CALDWELL	27.1	1				HOWELL					
	19a. Informant's Name/Relationship (Type LINDA LANT'Z/DAUGHT!			ng Address (Street a			-	,	vn, State, Zij 211:			
	20a. Method of Disposition 1	moval from State	emetery, crer	sition (Name of matory or other place RANCH CEMI			. 86		n - City or To	own, State ER, MARYLAND		
	21. Signature of Funeral Service Licensee	2/	22	2. Name and Addres	s of Facility	,			91	WILLIS ST.		
	Xoliat H. YU	refis	M	ERS-DURE	RAW I	UNE	RAL HOME	, P.A	• WES	STMINSTER, MI		
	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ati he that caused the death	n. Do not ent	er the mode of dying	, such as o	ardiac o	r respiratory arres	st,		Approximate Interval Between		
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, b. System 4 Country Count											
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
Med	IF FEMALE:		···									
Medical Certification: To Be Completed by Physician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3∟	Ectopic pregnancy Other (specify)	·		23d. Date of delivery Month Day Year					
ed by PI	Part II. Other significant conditions contr	buting to death but not resident	ulting in the ur	nderlying cause give	n in Part I.		23e. Did toba	s 2 No 3 Probably 4 Unknown				
Complet		V = 1327	···				24a. Was an autopsy perform		o. Were auto prior to co death? 1 \(\sum \text{Yes}	ppsy findings available mpletion of cause of 2 No		
Be (25. Was case referred to medical examiner?				26. Place	of Death	(Check only one					
0	1 ☐ Yes 2 No	spital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA Othe	4 🗆 Nur	sing Hon	ne 5 Aesiden	сө 6 🗆 С	ther (Specif	(y)		
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? es 2 □ N	- 1	8d. Describe how	injury occ	urred			
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		2	8f. Location (Stre City or Town,	et and Nui State)	mber or Rura	al Route Number,		
edical (29a. Certifier (Check only one) Certifying Physic 2 Medicel Exemine	cien: To the best of my kno er: On the basis of examinat and manner stated.	wledge, death tion and/or inv	n occurred at the time vestigation, in my op	e, date and nion, death	place, a	nd due to the cau d at the time, dat	ise(s) and e and plac	manner as s e, and due to	tated. o the cause(s)		
×	29b. Signature and title of certifier	John wa)	29c. License	number	5	290	_	ned (Month,	Day, Year)		
	30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print)			1.					
	MAGANBHAI PANSURIY	A M.D. 349	MALCO	LM DRIVE,	WES'	IMIN:	STER, MD	2115	7			
te ar	31. Date filed (Month, Day, Year) OCT 1 4 2004	32, Registrar's Signa		Sound		1)						
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Pł	nysicia	ın	Decedent's Name (First, Middle,	Last)				incate	- OI L			2. Date of De Month		Year	3. Time of Death	
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	neral ector		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$							th v. Year)	9. Birth	corges Iplace (State or Foreigr Intry) ginia				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Highiene.	int: if item 27 is marked other than "natural, or fiems 23a or 28a-1 show any or other traumatic event, the Medical Examinat rust be natified at any or other traumatic event, the Medical Examinat rust be natified at any funeral Director.		Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number 1246 Palmer Roa 11. Marital Status 1 Never Married (Specify only highest Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L Joseph A. Lac 19a. Informant's Name/Relationsh Edna M. Lacey/Da 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (Specify only highest) 21. Signatural Funeral Service L	ad 12. Was Dec Armed Find I Yes Gine Feducation grade completed) 2. College (ast) 4. Cy 4. Cy 5. Education grade completed) 2. College (ast) 4. Cy 6. Cy 6. Cy 7. Cype, Print) 8. Chemoval from acity)	redent Evorces? 2 2 Tho ve Dates:	16a In	lash 13. 1 Decece (Give life, I Ven Nailir 817 f Dispony, cremy, cremy	ingto 10f. Zip Nas Deced f Yes, spec f Yes, spec to Yes dent's Usua kind of wor DO NOT Us to Ty ag Address Fram stion (Namatory or of Mem.	ent of Hi fly Cuba Li Occupa k done of e retired, Mana (Street a ent ent ent Gar	specify: ation furing most ger 18. Mothe Juli and Number Ave.	or's Name a SI or or Rure #201 10/1	e (First, Middle Lade Al Route Numb Norfo	16b. Kind Reta , Maiden Su er, City or To lk, VA. 20c. Locat	Race - Amer Black, White Pecify: B1a of Business/limame) www. State, Zimame, State, State, State, State, State, Zimame, Stat	10d. Inside City Limits 1 □ Yes 2 ☒ No untry? fican Indian, , etc. a C k industry	
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Division of Vital Records, To the Hospital or Attsnding Physician: The law requires to within 24 hours after death.	ad in by the funeral director	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigates a Suicide 4 Homicide	28a. Date (Mon	of Injury oth, Day Y	r - At home, fa	Time of Injury	M 2	3c. Injury Work 1 🗆 \	r: 4 🗆 Nu	rsing Ho	me 5 Residence Service Residence Service Residence Resid	dence 6 Chow injury or	curred	fy) SCENE	
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	ems ern	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S	3. 13. V		lispanic Origin? (S an, Mexican, Puert	pecify Yes or N	0-	14. Race - Am Black, Whi	erican Indian,		
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Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 ie marked other than "naturel", or Items 23a or 28e-f show or other traumetic event, the Medical Examiner must be notified at		19a. Informant's Na				19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, State,	Zip Code)		
e)	1 and 2 Health tem 27 I		Tonya Vau 20a. Method of Disc		aughter	20h Pla	1542	Lovell C	t., #D,	Patuxen:	t Riv	ver, Mo	20670		
وّ	ages nt of h		1 🔀 Burial 2 [Cremation 3		cei	metery, crem	natory or other plac	·		S .	ocation - City or			
Ħ	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		1 X Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) Cethsemene Cemetery 9-11-2004 Detroit, Michigan 21. Signature of Funeral Service Licensee 22. Name and Address of Facility												
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Division of Vital Records, I	quires thain signed	ed by	SARCO		ontributing to death b	out not resul	ting in the un	derlying cause giv	en in Part I.		tobacco u Yes 2 (/	o the cause of death? robably 4 Unknown		
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	To the Hospite within 24 hours To the Funerel completely filled	edical	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best niner: On the basis o and manner st	of examination	rledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)		
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RJ 04-06370 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Howard Hill, Jr. State of Maryland / Department of Health and Mental Hygiene G838 12-2-04 tas Registrar Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** October 2, 2004 Howard Hill. 09:45 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Essex
If Under 1 Year

'donths Days Franklin Square Hospital Baltimore County

9. Birthplace (State of Foreign
Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XX 2 □ F Hours Min Yrs. 212 82 1836 45 May 29. Director 1959 Washington DC Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Tes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 Queens Purchase Road #B 21221 Items 23a United States Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ent: If item 27 is marked other than "natural", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Y Year or Dates. 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes 2 XN Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Maintenance <u>Equipment</u> treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Hill, Sr. Mary Bowles ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Hill (Wife) 1300 Queens Purchase Rd, #B, Essex, Maryland21221 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 7. 20a. Method of Disposition 20c. Location - City or Town, State 2004 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) permit, Page Department of Importent: If any injury or once. Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Juneral Service Al; exandria Ferry Rd, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only orfe cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multiple Drug Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): 68760 Be Completed by Physician/Medical Box esn esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death.

1 Yes 2 No 24a. Was an performed? 2 □ No Division of Vital Yes Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ★ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 XYes 2 ☐ No this 28a. Date of Injury **Found**Tound 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Hospitel or Attending After 5 Pending investigation 1 Natural Found death. 1 ☐ Yes 2 No Unknown 2 Accident Director: 10-2-04 8:40 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found at home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1300 Queens determined 4 Homicide Purchase Rd., Essex, Md 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. To the I To the 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number un your OCME October 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANTA 0254 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

rocks

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year 7:15 P M **Physician** September 27, 2004 Marjorie Duvall Halfpap /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Asbury-Solomons Island Health Center Calvert Solomons If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🛛 F 1916 South Carolina March 5, 88 Director 578-05-4446 Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State 10b. County rai', or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 🔀 No Sunderland Calvert MD Directo the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with U.S.A. 20639 6275 Alpine Ct. Completed by Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Copywriter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jessie Miles Louis R. Butler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) Jane Friel Sunderland, MD 20689 6275 Alpine Ct. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Oct. 2, 2004 Suitland, MD Washington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert P.A. Danielle Ward 3125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FARS ORGANG **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the first Underlyin J Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 ☐ Fetal death 3 Ectopic pregnancy Year Month jo Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. page 2 should be detached the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. 1 Yes 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No certificate 1 🗌 Yes 2 No To the Hospitel or Attending Physician: after death.

Director: After this certific.
In by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medicai Certification: 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Funeral Dir To the Funeral Dir 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SEPT-28 026358 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10845 Town Center Blvd. Dunkirk, MD 20754 John H. Weigel, M.D. 32. Registres Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Sept. 29, 2004 1645 SARA SHEPPARD HAND /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Grice Street Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 4-13-14 **Funeral** 1 □ M 2 5 E 146-07-1395 90 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show other than "natural", or items 23a or 28a-1 snov vent, it e Medical Examinar musi ke redified al Director Md. Worcester Berlin 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Grice Street Funeral 21811 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify.White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked Allen Sheppard Edith McElvee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 15 Carriage Lane, William E. Hand Son Ocean Pines, Md.21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If its any injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Salisbury Crematory 10-2 Salisbury, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility <u>Ullrich Funeral Home</u> Berlin, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myoceredial mmw623 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as nding I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death ned by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by been signe should be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No perlipidemic. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has tirector, page 2 s autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 ☐ No After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) Ille D30619 9/30/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Suite 150x1N Md 21811 10445 Ocean Libi Meter S AbbattomD 31. Date filed (Month, Day, Year) 32 degistrar's Signature State OCT 0 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Irene F. Harmon 04-6307 Unpend Item 23a,27,28a I per me 536 10-16-04 tas

State of Maryland / Department of Health and Mental Hygiene
The control of Death Reg. No. 1 - For State Registrar **AKG** Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2004 armon October 5:56 AM rene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 419 Laurel Street Pocomoke City
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Worcester 8. Date of Birth (Month, Day, Year) 3 - (1) - 5 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Months 212-66-1932 1 M 2 1 F Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner roughts notified at 1 No 2 No Director Como orce Kc 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 218 Items 23e by Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) House Keeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked Schoolticlo 1111am ဂ္ atherino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 J Harmon Chusband O(OMOKe 20b. Place of Disposition (Name of Date 20a Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 □Removal from State 22. Name and Address of Facility Singi 5 ☐ Other (Specify) 110-9-04 * 4 Donation +Mc Signature of Funeral Service Licenses Funoral Homa BENNIE Smith P.O. Box 331 any Approximate Interval Between Onset and Death POCONOKE 23a. mil filler the last, se, or conclications shock, or heart failure. List only on a rous caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Cocaine Intoxication /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1.△ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) at SCENE Hospital: ٥ 1XXYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Pour Page 16 (19) Pour Pour Page 16 (19) Pour Page 16 (19) Page 16 (19 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Found 5:52d 1 Natural 1 ☐ Yes 2 🛣 No 2 Accident 10-1-2004 after death Director: Unknown 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Royte Number, City or Town, State) 419 Laurel Street 4 📋 Homicide Scene Pocomoke City, Md 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MP 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State OCT 0 5 2004 Registrar

DHMH 17 Rev 1/2001

			4 101	partment of Health and Mentertificate of Death	al Hygiene									
	0		Decedent's Name (First, Middle, Last)	2. Da	ate of Death 3. Time of Death									
	Physici /Medio		BARBARA RUTH HUNTZBERRY	(ottember 30 2004 8:55 PM									
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death									
			WASHINGTON COUNTY HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	HAGERSTOWN If Under 1 Year If Under 24 Hrs. 8, Da	WASHINGTON ate of Birth 9. Birthplace (State or Foreign									
	Funeral Director		219-34-7315 1 M 2 M F 66 Yrs.		fonth, Day, Year) Country)									
			Usual Residence of Decedent											
	shov	ក	10a. State 10b. County 10c. City, Town or toward MARYLAND WASHINGTON	FAIRPLAY	10d. Inside City Limits 1 ☐ Yes 2 🖔 No									
	ours after death with the Marylan eal, or items 23a or 28a-f show Executed at	Director	10e. Street and Number	10f, Zip Code	10g. Citizen of What Country?									
	h with		17820 SPIELMAN ROAD	21733	U.S.A.									
	deat deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican	res or No- 14. Race - American Indian, , etc.) Black, White, etc.									
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	and 2 lealth al m 27 is her trau			320 SPIELMAN ROAD, FA										
Baltimore,	ges 1 at of He If itam or other		20a. Method of Disposition 1 □ Burial 2X Cremation 3 □ Removal from State 20b. Place of Disposition cemetary, cr.	20c. Location - City or Town, State										
Ë	parmit. Pages Department of important: If it in injury or o		'4 □ Donation 5 □ Other (Specify) SMITHSBU	URG CREMATORY 10/04/20	OO4 SMITHSBURG, MARYLAND									
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	To t To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)									
	1.2		Mynf	0325/8	10/1/04									
5	H. C		30. Name and address of person who completed cause of death (Item 23a) (Type	D325/8 D. Kudysmille	Md 21757									
State Registrar 31. Date filed (Month, Day, Year) 4 2004 32. Projector's Signature 8.														

			1 - For State Registrar	State of M	larylan		irtment of I		nd Mental Hy	giene	OOL.	32646
			Decedent's Name (First, Middle, La	ast)	-				2. Date of De			3. Time of Death
	Physici		Cor	lyss Sea	lv	Kirko	atrick		Month	Day	Yeer 25 2004	11:05 P M
	/Medic Examin		4a. Facility Name (If not institution, gir				4b. City, Town,	or Location of D			County of Death	
н	Excitin.	<	Frederick Memor	rial Hospi	tal		Frede	rick			Frederi	ck
	Funeral				ge (In yrs. I	ast birthday)	If Under 1 Year		Hrs. 8. Date of Bi	rth	9. Birth	aplace (State or Foreign untry)
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	shov	5	Maryland Frede	w i ole		ederio						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	a or	급	1245 Dahlia Lane				21703					,
	eath	era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V		Hispanic Origin	i? (Specify Yes or N		nited St 14. Race - Amer	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show appring yor other traumatic event, I'm Mc diod Ever in artifical Exercising DDCs.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	? No	ŀ	Yes, specify Cub ☐ Yes 2 12 No	an, Mexican, P	uerto Rican, etc.)		Black, White Specify: Whi	, etc.
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	Hospital or Atteno 24 hours after deatl Funerel Director: tely filled in by the	3	29a. Certifier 1√ Certifying P	hysician: To the best	of my know	wledge, death	occurred at the ti	me, date and n	lace, and due to the	cause(s)	and manner as a	tated
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	(o		30. Name and address of person who			23a) (Type, I						-1
	V		A.L. Villanov	a, M.D. 40	00 W.	7th St	reet, Fi	ederic	k, MD 2170	01		
(a)	State SEP 3 0 2004 SEP 3 0 2004 32. Registrar's Signature											

			For SI = State Registrar	ate of Maryland / Depa	artment of Health and Natificate of Death	fental Hygier	2001 0	3261.7
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Kirkwood		2. Date of Death Septemb	Day Year	3. Time of Death
	Examir Funeral	er	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Princess Ar If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Some y 9. Birthpla	ace (State or Foreign
	Director		2 15 - 16 - 836 1 □ M Usual Residence of Decedent 10b. County	10c. City, Town or Lo	cation	2-14-	-12 Mar	d. Inside City Limits
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Balti	permit. Pag Department Important: I arry injury o		21. Signature of Tuneral Service Licensee		Name and Address of Facility	thon &	Ward F.	H. md 21853
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	⊢ 3 - 8	ı	30. Name and address of person who comple	ated cause of death (Itam 22a) (Turn 1	847094	-	9/24/04 BURY MD	
RM		to	UEU NATE SAN 31. Date filed (Month, Day, Year)	1415 Sount 32. Registrar's Signature	DIVISION STAFFT	5445	gury nd	21804
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year tember 22,200 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Hopkins ar If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Months Hours Min. 1**⊠**M 2□F 578-42-4034 76 Yrs. Director WASHINGTON, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director MARYLAND MONTGOMERY CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2313 WASHINGTON AVENUE death v 20815 U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 1 M Yes 2 □ No 1 Yes, Give Year or Dates: 1946-48 14. Race - American Indian, Black, White, etc. "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MERCHANT MEN'S FURNISHINGS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MINNIE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY C. KLEIN/WIFE 2313 WASHINGTON AVE., CHEVY CHASE, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEM. GARDENS 09/26/2004 OLNEY, MARYLAND 21. Signature of Funeral Service DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 onald. 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician gan /Medical Due to (or as a consequence of) **Examiner** lening Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1+ Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte d be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part #. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? tailure 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2**X**No 1 Tes Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 28h Time of 27. Manner of Death 28d. Describe how injury occurred al or Attending P s after death. I Director: After Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of c 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2004

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND ITEM #21 PER FH G836 1079 15 15 16 16 Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WILLIAM MCCAFFREY LEISTER OCTOBER 6:15 PM M 2, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL WESTMINSTER 192 MARION ROAD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Birthplace (State or Foreign Country) 1 XM 2 ☐ F Months Director MARCH 28, 1921 MARYLAND 83 160–18–0321 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Evandras must be notified at 1 ☐ Yes ZONo Director WESTMINSTER MARYLAND CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 UNITED STATES 192 MARION ROAD or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or iter any injury or other traumatic event, Ita Medical Everning. 9088. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: WHITE by If Yes, Give Year or Dates: WWII/KOREA 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PLUMBING & HEATING 4 PLUMBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARVEY ABRAHAM LEISTER BESSIE MCCAFFREY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY A. LEISTER/WIFE 192 MARION ROAD, WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State WESTMINSTER, MARYLAND MEADOW BRANCH CEMETERY 10/5/04 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A.
91 WILLIS STREET, WESTMINSTER, MD 21. Signature of Funeral Service Licenses JUSTIN R. DURBORAW per DVR 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stag **Physician** ind 20 mo /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? The law certificate has autopsy 2 X No 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Watural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á after 4 Homicide within 24 hours a To the Funeral D pelli 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 1 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MO low 140223

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Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

State Registrar

31. Date filed (Month, Day, Year) OCT 1 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REBECCA A. GOEDEKE M.D. 32 registrar's Signature

4231 NORTHWOODS TRAIL, HAMPSTEAD, MD 21074

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 27, 2004 **Physician** Month Norma Elizabeth Leppanen September 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Sunrise Assisted Living Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 26, 1918 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2183 F 013-12-6818 86 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location orient: If item 27 is marked other then "natural", or items 23e or 28e-1 show injury or other treumatic svent, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Frederick 1 XYes 2 No Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 990 Waterford Drive 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2월 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Teacher High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emil Leppenan Alina Ahokangas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Levy / Nephew 3800 Charles Ave., Alexandria, VA 22305 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Sept. 30, 20c. Location - City or Town, State 1 □ Burial 2 ACremation 3 □ Removal from State permit. Page Department of Importent: If any injury or genee. Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Eggeral Service Licensee Resthaven funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the dispase shock, or hear failure. or conjuncations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner use as the burial-tran the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably 4 Unknown 1 Yes 2 No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 TYes Hospitel or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED To Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) the funeral 27. Manner of Death 28b. Time of Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number 5 861 Tall House 32. Registrar's Signature State Registrar 2004 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 32651 Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** optem ber 30, 2004 1157 AM William Theodore Light, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hagerstown Washington County Hospital 6. Sex 1**X** M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 27 1921 Birthplace (State or Foreign Country) **Funeral** Days Hours 83 Yrs. Maryland Director 213-18-9252 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show rthan "natural", or items 23e or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 U.S.A. 153 North Colonial Drive 12. Was Decedent Ever in U.S. Amed Forces? 1&1Yes 2 □ No 1939 If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Insurance Agent 12 traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be file partment of Health and Mental Hy partant: if item 27 is marked oth y njury or other traumatic avant Lilly Bell Everhart James Monroe Light 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 153 North Colonial Drive Hagerstown, Maryland 21742 Beryl V. Light (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Oct. 1, 04 Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit.
Dep.rtm
Impurta
any nju 21. Signature of Pyneral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Estern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ENCEPHALOPATH 7.5 HUS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ~ FARCTION WAS CARDIAC Myocandian Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit TUPOXEMIA resulting in death) Last to (or as a consequence of): Box 68760, ZOI-PATHIC PULMONARY FIBRUSIS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de. 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an NEUMONIA autopsy performed? 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Change Hongto TR Do051395 OGOBER 01, 2004 Mich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMPUS RO: SUITE 107, HARENSTOWN, MO 21742 JILLIAM E. Noys FEN. M. D.

31. Date filed (Month, Day, Year)

OCT 0 4 2004

32. R 11110 MEDICAL Registrar

		•	For State Registrar	State o	of Mar	yland		artment of rtificate o			nd M	ental Hyg F	giene Reg. No. 🗘	0.01	00000
			Decedent's Name (First, Middle, Lass)							Ī	2. Date of Dea	ıth i	UUA	3. Time of Death
	Physicia	an	Zada Rose Lo	-	ær							Octobe	c 3 Day	2003	3:00AM M
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M _i	Examin	er	Coffman Nursi					Hac	ers	town			Was	shinata	on County
	Funeral		5. Social Security Number 6. Se	×		(In yrs. la	st birthday)	If Under 1 Ye	ar I	f Under 24	4 Hrs.	8. Date of Birth (Month, Day			nplace (State or Foreign intry)
	Funeral Director		219-36-2849]м 21 Х .F		87	Yrs.	Months Da	ys	Hours	Min.	January (nnsylvania
*			Usual Residence of Decedent									1			
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	h the	Director	10e. Street and Number				,	10f. Zip Cod					-	n of What Cou	untry?
	th wil	a	1304 Pennsylvania	Ave.					742					.S.A.	
	ema ema	Funeral	11. Marital Status	12. Was Dec Armed F	edent Evorces?	er in U.S	. 13.	Was Decedent	ol Hisp Suban,	anic Origi Mexican,	in? (Spe Puerto	cify Yes or No- Rican, etc.)		Race - Amer Black, White	, etc.
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Ĕ	2 should be filed within 72 hours after death with the Marylan and Menial Hygiens. Is marked other than "natural; or Itema 23a or 28a-f show aumatic event, the Medical Examiner must be mailified at	Be	George M. Straley							pl ₂	nche	Alverta	a Honr	ale	
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Maryland 21215-0036	12 sin and 17 is r			aughte	r)			-							and 21740
	1 and Health em 27 ther t		20a. Method of Disposition	augirce		20b. Pla	ace of Dispo	sition (Name o	f		С	ate	20c. Locat	tion - City or 1	Town, State
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altimore,	rt Pa		* 4 □ Donation 5 □ Other (Specify 21. Signature — uneral Service Licen			Jood									
Ba	permit. Pages 1 and 2 should Deportment of Health and Men Important: If item 27 is marke any injury or other traumatic once.		1 Laniel	2. thu	ley	Tr.	13	31 East	err	ı Blv	d. 1	1. Hage	rstow	y Fune n Mary	ral Home land 21742
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on	each line	9.	. Do not ent	ter the mode of	dying,	such as c	ardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	enti										10 yrs
	/Medical Examiner		Due to (or as a consequence of): Diabetes Mellitus										10 yrs		
		-	Sequentially list conditions,	b	(or as a										10 312
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		•										
	ficate be executed physician and is the burial-transit	Xar	that initiated events resulting in death) Last	Due to	o (or as a	consequ	ence of):						·- · · · · · · · · · · · · · · · · ·		
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	death certific e attending p ed for use as	by Physician/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, o									230	d. Date of deli	very
Вох	death atte	Cia	in the past 12 months?	4∐Preg	birth 2 gnant at t			⊒Ectopic pregn ⊒ Other <i>(specif</i>)						Month	Day Year
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ص	requires that the been signed by th hould be detache	Y P	Part II. Other significant conditions of	ontributing to	death but	t not resu	tting in the u	ınderlying caus	e given	in Part I.		23e. Did te	obacco use	contribute to	the cause of death?
ds	n sign											1 🗆 '	res 201	No 3□Pro	obably 4 Unknown
Vital Record	> 40	Completed										24a. Was		24b. Were au	topsy findings available
Re	The law ate has b	Ę											rmed?	death?	completion of cause of 2 No
a	ician: Th certificate rector, pag	e C	25. Was case referred to medical							os Place	of Det	1 ☐ Yes n <i>Check on</i> o	2 No	1 1 103	2 140
⋚		8	examiner?	Hospital:	Inpatien	t 2 🗆 I	ER/Outpatie	nt 3 DOA	Other		-	me 5 Resid		Other (Spec	oify)
of	Phys or this oral di); To	27. Manner of Death	28a. Dat	e of Injun	/	28b. Time o		Injury a			28d. Describe I			,,
on	ding Ph th. : After thi funeral	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		onth, Day	Year)	Injury			es 2 🗆 N	10				
İSİ	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	200. Fla	ce of Inju	ry - At ho	me, larm, st	reet, factory, of	fice		1			Vumber or Ru	ıral Route Number,
Division	Dir	ertification;	4 Homicide	buil	ding, etc.	. (Specify	7					City or To	wii, Siale)		
_	Hospital 24 hours a Funerel I	O	29a. Certifier 1 Certifying Pl												
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Examone)	niner: On the and ma	basis of inner stat	examinat ted.	ion and/or ir	nvestigation, in	my opi	nion, deat	n occur	ed at the time,	date and pl	ace, and due	to the cause(s)
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			- CAMIK	1 (1	AIV	14	1	D.	366	55			Oct ·	4, 200	4
	4.4		30. Name and address of person who	completed ca	use ol de	ath (Item	23а) (Туре	, Print)							
5			Samuel Chan MI	324 A	ntie	tam	st. H	Magersto	wn	Mary	land	21740		· · · · · · · · · · · · · · · · · · ·	
	St	ate	31. Date liled (Month, Day, Year)		Registra			(and)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND ITEM # 24a.25&26 PER GARTIFICATE OF PATO 104 Jh 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** July 30, 2004 en 12:00 PMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ass. Montgomery VI Village MONTGOMERY Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 369-34-5389 Months Days Hours Min 1□M 2**X**F 18 85 Yrs. Illinois Director 0-14 Usual Residence of Decedent the Maryland 10c. City, Town or Location MERY 10d. Inside City Limits 10b. County 10a. State 28a-f show item 27 is marked other then "natural, or items 23e or 28a-f shot other treumatic event. Its Madical Examples in mailled at 1 ☐ Yes 2√ No MD Director Montgomery Montomgery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 19310 Clubhouse Road 20886 USA Funeral 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white δ 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 automotive secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank E. Hoag Jeanett Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 Duvall Lane #T1 Gaitherburg, MD Tyler Mahy/son 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Licensee Ronald S. Wade Divertor nuel Baltimore, MD 21201 23a. Part Enter the disease, or implications that leased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) Brain Physician Organic /Medical Due to (or as a consequence of): Examiner railure MOS. Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence off Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nther (Specify) ဥ 2 No 1 🗌 Yes this LIVING 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 5 Pendina after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar 31. Date filed (Month, Day, Year) OCT 1 4 2004

Sunair

29b. Signature and title of certifier

32. Registrar's Signature

15215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abultaray

DHMH 17 Rev 1/2001

29c. License number

Shady Grove Rd #100 ROCKINE, MD 20850

29d. Date signed (Month, Day, Year)

25

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar AMEND FIFM #23a PER PHY G836 10/14/04 JH

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year SIDNEY LEE MORGAN SEPT. 23, 2004 10:19PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL LA PLATA CENTER CHARLES 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours XXM 2 F Director 225-12-9628 82 JUNE 12,1922 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral, or items 23a or 28a-f shore MARYLAND CHARLES LA PLATA 14 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 MAGNOLIA DRIVE 20646 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ No If Yes, Give Year or Dates: 1 9 3 9 − 1 9 4 5 1 ▼ Yes ▼ No If Yes If Yes ■ 1 ▼ No If Yes 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify: 3X Widowed 4 ☐ Divorced Specify: WHITE "natural" Completed than "natur Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MAINTENANCE TECHNICIAN U.S. GOVERNMENT Health and Mental Hygitem 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be CHARLES GORDON MORGAN LUCY IRENE BARNETT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL JACKSON-DAUGHTER 116 QUAILWOOD PARKWAY, LA PLATA, MD 20646 E 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, Stete permit. Peges 1 Department of H Important: If Ite any injury or ot once. Murial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GDNS 9-27-04 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 23a. Part 1 Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Pnysician ASPIRATION **PNUEMONTA** minutes /Medical Due to (or as a consequence of): Examiner CENESNO VASCULAR ACCIDENT years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of). Examiner The law requires that the death certificate be executed attending physician a for use as the burial-Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by CHILDRIC OSSTRUCTIVE PULMONARY OLSEASE 3 probably 4 □Unknown 1 ☐ Yes 2 ☐ No been PALKINSONISM 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page GASTRO EST PHA GEAL REFLUX certificate 1 ☐ Yes 217 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 was , and D53592 9(24/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALRONG, MD ECCOL ARNEL EASTREVICE 12070 OLDLINE CTAL STELOU 31. Date file Worth, Pay Y 2004 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / De State of Maryland / De State Amend : Item 21per DVR G-836C	partment of Health and Ment											
			Registrar Afficiation - Itelia 21 per BVR G 6500 Decedent's Name (First, Middle, Last)		Reg. No.										
н	Physici		Pauline M. Matthews	N	fonth Day Year										
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	tober 8 2004 10:10A ^M										
4.	Examin	E	14614 Main St. SW	Cresaptown	Allegany										
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthd)		ate of Birth 9. Birthplace (State or Foreign										
×	Director		219-22-8912 ^{1□M 2} To yrs	Months Days Hours Min. (A	ot 1,1925 Maryland										
	pu ,		Usual Residence of Decedent												
	ehow	-	10a. State 10b. County 10c. City, Town o		10d, Inside City Limits 1 ☑ Yes 2 ☐ No										
	Me M	Director	Maryland Allegany Cresa	•											
	with ti	급	10e. Street and Number 14614 Main St. SW	10f. Zip Code	10g. Citizen of What Country?										
	s 234	ıral		21502	USA /es or No- 14. Race - American Indian,										
	Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican 	n, etc.) Black, White, etc.										
336	urs af	by	If Yes, Give 3 XWidowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: White										
5-0036	filed within 72 hours after death with the Maryland tyglene. ther then "natural", or Items 23e or 28e-f ehow ont, the Medical Examiner mat be multified at	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b. Kind of Business/Industry										
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Maryland	2 sh and Is m			ailing Address (Street and Number or Rural Rou											
_	1 and Health em 27 ther tr	Cresaptown, MD 21502													
1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)															
tim	t. Pa timen tant:		'4 Donation 5 Other (Specify) Laurel Hill Cem. 11,2004 Moscow, MD												
Bal	permit. Pag Department Important: eny injury o		Magazial 2 Cremation 3 Removal from State Cemetery, crematory or other place) Oct 1												
			23a Part 1 Enter the disease or complications that caused the death. Do not		•										
			shock, or heart failure. List only one cause on each line.		Onset and Death										
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
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		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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ó	exec an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):												
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d												
9	ntiffice ng ph s as tl	Med	IF FEMALE:												
Вох	ath ce Itendi	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	23d. Date of delivery Month Day Year										
_	that the death certific ed by the attending p detached for use as	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)	Manin Say Tour										
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ds,	signed to det	Completed by	CONGESTIVE HEART	FAILURE	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown										
Š	w require been si should I	ete	PANIADEATIN MACC												
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Ξ	Physician: this certific ral director,	8	examiner? 1 Yes 2 10 Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Che ient 3□ DOA Other: 4□ Nursing Home 5	ck only one) 5-Aesidence 6 □Other (Specify)										
of	g Phy er this eral d	ا: 1 ₀	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. D	Describe how injury occurred										
ion	nding ath. r: Afte e fun	atlo	1 Natural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No											
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Ö	telor safte al Dir	Certification:	Building, oto, (opcomy)												
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) (Check only one) (2 ☐ Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, and du investigation, in my opinion, death occurred at t	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)										
•	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)										
)			Ann Holaman	D0054004	10-11-04										
			30. Name and address of person who completed cause of death (Item 23a) (Ty												
_			DR. SHIV KHANNA 1221 N	ATIONAL HUY LA	VALE MD 21502										
	Sta		31. Date filed (Month, Day, Year) 32., Registrar's Signature	Some that											
	Registr	वा	OCT 1 4 2004	July or and a second											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2004 Physician Month Year 07, OCT. 5:15 P. M SISTER JULIE McDONOUGH /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner FREDERICK ST. VINCENT CARE CENTER EMMITSBURG If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. JUNE 28, 1920 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign **Funeral** Months 1 ☐ M 2 🛛 F PENNSYLVANIA 217-54-9859 Yrs. 84 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ent: If item 27 is marked other than "natural", or items 23e or 28e-1 show ury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo **EMMITSBURG** FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21727 335 SOUTH SETON AVE. U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 💆 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry RELIGIOUS COMMUNITY Elementary/Secondary (0-12) College (1-4or 5+) NOTRE DAME de NAMUR TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN E. McDONOUGH JULIA HOLL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 S. SETON AVE., EMMITSBURG, MD. 21727 SISTER MARY ADELE WHITE/SUPERIOR Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of t
important: If ite
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) SISTERS OF NOTRE DAME 10/13/04 ILCHESTER, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner vous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No jo Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 3 Probably 4 Unknown 1 ☐ Yes 2 🔯 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page certificate 2 □ No 1 Yes 2 X No 1 Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification; To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a Medical 29a. Certifier 🔯 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Negrical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and tiple of 29c. License number 29d. Date signed (Month, Day, Year) 8 OCTOBER 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Fint) 310 S. SETON AVE., EMMITSBURG, MD. 21727 ALAN CARROLL, M.D., 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

32, Registrar's Signature

4 2004

			For State Registrar		State o	of Maryla	and / Dep <i>Ce</i>	artmen rtificat				lental Hy	giene	004	325	5.7
	Discordad		1. Decedent's Name (First,	Middle,	Last)							2. Date of De	ath		3. Time of	Death
	Physici /Medio		CARL WES	LEY	MORELAND							Octobe	r 5,	2004	3:28	A M
1	Examir		4a. Facility Name (If not ins	titution,	give street and nu	mber)		4b. City,	Town, or	Location	of Death		4c. C	ounty of Dea	th	
		9	Memorial Ho	-					erla		0411-			legany		
г	Funeral Director		5. Social Security Number 234-26-9598	6	3. Sex 1 ☐ M 2 ☐ F		rs. last birthday Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	iv. Year)	9. Bir	thplace (State o	or Foreign
			Usual Residence of Deced	ent	X	86						10-16-	1917		WV	
	yland		10a. State 10b. 0	ounty		10c.	City, Town or L	ocation							10d. Inside C	ity Limits
	e-f sl	ctor	WV	GR	ANT		M	OUNT	STOR	M					1 □Yes	2 X No
	ith th	Director	10e. Street and Number					10f. Zip	Code	•			10g. Citize	n of What Co	ountry?	
	ath w		HC 76 BOX 6	46	····				267	39				USA		
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. bd other then "netural", or items 23a or 28e-1 show event, the Medical Evanimer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Div		12. Was Deci Armed Fo 1 Tyes If Yes, Gir Year or D	orces? 2. ⊡xi No ve	1 U.S. 13.	Was Deced If Yes, spec	offy Cubar	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		. Race - Ame Black, Whit pecify:		
5-0	72 h "netu	etec	15. De (Specify only	cedent's highest	Education grade completed)		(Give	dent's Usua kind of wor	rk done a	lurina mos	t of work	ing	16b. Kind	of Business	/Industry	
12	e filed within II Hygiene. other then "	Completed	Elementary/Secondary (-12)	College (1-4or 5+)		ENDLO	,		A TOD		ATT	ECANY	MINING	
2	filed y Hygie other i		17. Father's Name (First, A	iddle, La	ist)			ENDLO	ADEK			e (First, Middle			MINING	
Maryland	2 should be and Mental is marked o	To Be	OLIVER ROSE	LL M	ORELAND					EI	ITH	MYRTLE	COSNE	ER		
Ma	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Re				1					Al Route Numb			Zip Code)	
	s 1 and 3 Health item 27 other tr		ANGIE I. MO 20a. Method of Disposition	KELA	ND/ WILE	201	. Place of Disp	osition (Nan	ne of			ORM, W		tion - City or	Town State	
non	0 0		1 ▲Burial 2 □ Crem			State	cemetery, cre	matory or of	ther place	9)	10 7	2004				
Baltimore,	- 들면 등	1	21. Signature of Funeral S			B	LKIRE C			s of Facilit		7-2004		T STO		
B	permi Depa Impo any ir		/ Jam	US	700	pel	U s	08 VI chaef	RGIN fer	IA AV Funer	ei'B	CUMBERI lome, Po	LAND, etersb	MD 21	EPA 502 for	
	Pnysician ·		23a Part . Effer the diseashock, wheart failure Immediate Gause (Final disease or condition	se, or co List or	ny one cause on e	aused the de each line. EMIA	eath. Do not en	ter the mode	e of dying	, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Beth Onset and I 4 YEARS	ween Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):												,	
6		20	Sequentially list conditions if any, leading to immediate	. 52	b	(or as a cons	equence of):									
	ted insit	Examiner	Cause (Disease or injury	~		(0. 20 2 00.10	040000 0.7.									
<u>,</u>	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	- 1	c	(or as a cons	equence of):									
8760,	e be sicia e bur	dicail		Ų	d											
9	tificat ig phy as thi	ledi														
Вох	death certific e attending p id for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregna		23c. If yes, out	tcome of preg		∃Ectopic pre					23d	I. Date of deli	ivery	
	ne deat the att	sicla	in the past 12 months 1 Yes 2 No	?		ant at time o		Other (spe						Month	Day Y	'ear
P.0	⇒ > ⊃	hy	9 Unknown													
Records,	w requires that been signed b should be deta	by	Part II. Other significant of HYPERTENSIO		s contributing to de	eath but not r	esulting in the u	nderlying ca	use give	n in Part I.		23e. Did to			the cause of de	
000	> 0 70	Completed	RENAL FAILU	RE								24a. Was		4b. Were au	topsy findings a	available
	9 4 9	Eo	BACTEREMIA									autop perfo 1 Tyes	rmed?	death?	completion of ca	use of
Vital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to mexaminer?	edical						26. Place	of Death	Check on o		1 🗆 103	20110	
of V	ys diii	To	1 ☐ Yes 25No				☐ ER/Outpatier	nt 3 DO	A Other	r: 4□N⊔	rsing Hor	ne 5□Resid	dence 6	Other (Spec	cify)	
	ng Ph		27. Manner of Death 1. ☑Natural 5 □ F	ending	28a. Date (Mont	of Injury th, Day Year)	28b. Time o Injury	f 28	Bc. Injury Work	at		28d. Describe h				
sio	Attending r death. ector: After by the fune	cati	C	ovestigat	be			М		es 2 🗆 l	No					
Division	or At	Certification:		etermine	ad 286. Place	of Injury - At ng, etc. <i>(Spe</i>	home, farm, str cify)	eet, factory,	office		2	28f. Location (S City or Tox		lumber or Ru	ral Route Numb	ner,
_	Hospitel or Attending I 24 hours after death. Funerel Director: After tely filled in by the funer		29a. Certifier 1	rtifving	Physician: To #-	hast of	nowledge de :	haaris		n det-	d ml = =	and division to the				
	9 Hos 24 hc 9 Fun etely	edical	(Check only 2 Me	dical Ex	Physician: To the aminer: On the ba and mann	asis of my k asis of exami ner stated.	nation and/or in	vestigation,	in my opi	o, uate and inion, deat	h occurre	and due to the o ad at the time,	date and pla	a manner as ace, and due	stated. to the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title	ertifier		. ^	1	29c.	License	number			29d. Date si	igned (Month	n, Day, Year)	
	,- > - 0		•	K	0-1	La L	0		D31	875			Octob	er 5	, 2004	
•	j		30. Name and address of p	erson wh	o completed caus	e of death (It	em 23a) (Type.	Print)	דרת	015			OCTOL	YET O	, 2004	
	1		Dr. Robert						308,	Cumb	erla	and, MD	2150)2		
	Sta	te	31. Date filed (Month, Day,	Year)	32.	egistrar's Sig										
2	Registr	ar	6071	4	U4 A	Encin-2	12	Apa	K	/						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Manges Irene OCTOBER 4. 2004 17:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CUMBERLAND
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. MEMORIAL HOSPITAL ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Apr 27, Birthplace (State or Foreign
County) **Funeral** Months 1 ☐ M 2 🔀 F Director 95 218-52-6697 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at MD Allegany Cumberland Director 1X Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 314 Arch Street 21502 USA or items 23a Funera 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after de Il Hygiene. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic event, <u>ones.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Athey Mary J. (Willard) Athey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address, (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Braddock Avenue LaVale MD 21502 James Manges son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Davis Memorial Cemetery 10/8/2004 MD Cumberland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nan**Scarbent Puneral** Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, drheart failure. List only one cause on each line.

Immediate Cause (Final disease or Indition CONGESTIVE HEART FAILURE Approximate Interval Between Onset and Death Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). The law requires that the death certificate be executed as the burial-tran resulting in death) Last Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 2 □ No · 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident rector: , by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours. the Funeral Directory filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5,200 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POONAI, VIK, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502 32. Registrar's Signature 31. Date filod (Month, Day, Year) OCT 1 4 2004 Registrar

-	1- State Unpend Item Registrar		,27,28a-F	per me	of Dea	If-I6			004	99770
Physician	1. Decedent's Name (First, Middle, L William	.as;) am Joseph M	cLaurin				2. Date of Do	Day	Year	3. Time of Death
⊀Medical Examiner	4a. Facility Name (If not institution, g			4b. City. To	own, or Loca	ation of Dear	Octo		2004 county of Deat	7:57 P M
LAdminer	Southern Mary]		al Center		nton		,			eorge's
Funeral		Sex 7. Ag	e (In yrs. last birthda)) If Under 1	Year If U	Inder 24 Hrs		rth av. Year)	9. Birtl	hplace (State or Foreign untry)
Director	Usuat Residence of Decedent	1 \L \L\ 2\ F 6	/ Yrs.				2/14/1	937	Nor	th Carolin
Mo tal	10a. State 10b. County		10c. City, Town or I	ocation						10d. tnside City Limits
28a-f show notified at	Maryland Prince	George	Camp Spri	.ngs						1 ☐ Yes 2 X _XNo
be notified	10e. Street and Number			10f. Zip C	ode			10g. Citize	n of What Co	untry?
ms 23a	6610 Howie Court					2074		US		
trem 27 remarked brief manuar, or remarke of 208-1 sho other treumstic event, the Mudical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married		13 to 1956-			ic Origin? (S exican, Puer	Specify Yes or No to Rican, etc.)	o- 14	Black, White	
E.	3XXWidowed 4 □ Divorced	tf Yes, Give Year or Dates:	1960	1☐ Yes 2☐	No Spe	ecify:		S	pecify: Wh	iite
it, the Medical I	15. Decedent's (Specify only highest of		16a. Dec	edent's Usual (Occupation done during	most of wo	rkina	16b. Kind	of Business/I	industry
m ldm	Elementary/Secondary (0-12)	5+ Cotlege (1-4or 5		e kind of work DO NOT use trical			9	Feder	ral Cov	ernment
CO CO	17. Father's Name (First, Middle, Las						me (First, Middle	J		eriment
To Be	Brady Joseph McI						auline H		umame)	
umat	19a. Informant's Name/Relationship		19b. Mai	ing Address (S			ural Route Numb		own, State, Z	ip Code)
er tre	Patti M. Tully/I	aughter					at Mills			
r of	20a. Method of Disposition 1 Darial 2 Deremation	Weamoval from/State	20b. Place of Disp cemetery, cre	matory or othe	er place)		Date		tion - City or 1	
jury	* 4 □ Donation S □ Other (Spec	cify)								City,N.C.
any injury or other tre	21. Signatur Funeral Service Lice	clas of	6	160 0xc	on Hil	1 Rd.	o. Kalas Oxon Hi	111, M	eral Ho ID. 207	me 45
	23a. Part 1 Enter the disease, or co- shock, or heart failure. List only	mplications that caused y one cause on each lin	the death. Do not er ne.	ter the mode o	of dying, suc	h as cardia	or respiratory a	rrest,		Approximate Interval Between
cian dical	tmmediate Cause (Final disease or condition resulting in death)	a. Stab Wou	und of Che	st						Onset and Death
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I Ex	resulting in death) Last	Due to (or as a	a consequence of);							
음	•	d								
age z should be detached for use as tompleted by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome	of pregnancy					224	d. Data of data	
hysiciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at		□Ectopic pregi □ Other (speci				230	d. Date of detive Month	Day Year
hys	9 🗆 Unknown	9□ Unknown								
be det	Part II. Other significant conditions		it not resulting in the i	inderlying caus	se given in P	Part I.				the cause of death?
should a	Parkinson Diseas	е		_			101	Yes 2 💢 1	No 3∏Pro	bably 4 □Unknown
mple							24a. Was autop	ysy	prior to co	opsy findings available ompletion of cause of
5 G							1 X Yes	rmed? 2□No	death? 1 IXI Yes	2 □ No
irector	25. Was case referred to medical examiner? 1XXes 2 □ No	Hospital:	0 FB FD (0		Out		th (Check only o			
eral dir	27. Manner of Death	28a. Date of Injury (Month, Day	y 28b. Time o	f 28c.	Injury at Work?	_ Nursing H	ome 5 Resident			<i>fy</i>)
e funer	1 Naturat 5 Pending 2 Accident investigation	n 10-6-200		alm	Work? 1 ☐ Yes 2	2 X No	Unknown			
ed in by the funera	3 ☐ Suicide 6 X Could not 4 ☐ Homicide	ho -	ry - At home, farm, st . (Specify)	reet, factory, or	ffice				lumber or Run	al Route Number,
		Residenc	e				Camp Sp:	rings	, Maryl	and
mpletely filled in by the to	29a. Certifier 1 Certifying P (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	examination and/or in	h occurred at to vestigation, in	he time, date my opinion,	e and place death occu	, and due to the or rred at the time, or	cause(s) an date and pla	d manner as s ace, and due t	stated. o the cause(s)
completely f	29b. Signature and title of certifier				icense numb			29d. Date s	igned (Month,	Day, Year)
	I him h	i. mid		0.	C.M.E.	•		Oct	tober 7	, 2004
	30. Name and address of person who		eath (Item 23a) (Type,	* .	Done C	2+	Delt.		Marri 7	
Chris	31. Date filed (Month, Day, Year)	OO Desistes	r's Signature				, Balth	iore,	Maryla	and 21201
State Registrar	ncT1 4	h #	rs Signature	1 40	neles	/				

Bilal Mustafa Amend item # 5, per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 04-06173 DOS 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year BILAL FAREED MUSTAFA September 25, 2004 2203 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center La Plata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jan. 13, 1953 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) Months Days Hours Min. 1[XM 2□ F Virginia 51 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any higher or other traumatic event, If a Miculcal Examiner must be notified as once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Charles WALDORF Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11705 Cob Court 20601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Section Leader Washington Gas 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) William Thomas Brown Rena H. Doles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therion Mustafa- Wife 11705 Cob Court, Waldorf, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State George Wash Cemet, 9-29-04 Adelphi, Maryland 4 Donation 5 Other (Specify) To uneral Service Licensee 22. Name and Address of Facility Universal II Mortuary Inc. 21. Sign ud 4II Kennedy St, N.W., Wash, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensine atheroxdonotic Cardiovascular disease /Medical Due to (br as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical as the IF FEMALE: USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 AUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? 1 Yes 2 No nours after death.

neral Director: After this certifical filled in by the funeral director, in 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2√ ER/Outpatient 3 DOA Other: Certification: To 1 XYes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

Medical

LING 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

29 SEP 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

hi.

LI

32. Registrar's Signature

and manner stated

m. D

oakid

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

29d. Date signed (Month. Day, Year)

111 Penn Street, Baltimore, Maryland 21201

September 26, 2004

To the Hospital within 24 hours a To the Funeral Completely filled in a completely filled i

Amended item Amended item	#11For per/ F. Home 1- State Registrar# 25 & 31	State of Marylan per/physician,	d / Depa	artment of H	ealth and I	Mental Hy	Reg. No. WCH	/5/04 E.T, WCHD D, E.T, 266			
Physician	Decedent's Name (First, Middle, III)	Last) ONALD FRANCI	re Mi	ANGER		2. Date of De. Month	Day 27, 20	Year 0.4 2043 M			
/Medical Examiner	4a. Facility Name (If not institution, g		LO M	4b. City, Town, or	Location of Death	Sept.	4c. County	<u> </u>			
	11416 Ocean Ga			Berli				ester			
Funeral Director	5. Social Security Number 2.13-58-2413 Usual Residence of Decedent	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 1-18-	th y, Year) ·53	Birthplace (State or Foreign Country) MD			
/land	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits			
e-feh	Md. Worces	ter Oce	ean P	ines				1/2 Yes 2 □ No			
vith the Mar or 28e-1 et be ricillisa	10e. Street and Number 40 Beaconhill	Da		10f. Zip Code	1 1		10g. Citizen of V	Vhat Country?			
eath v	11. Marital Status	12. Was Decedent Ever in U.	S 13 1	218		pecify Yes or No	USA 14. Raci	e - American Indian.			
faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental hygiene. is marked other than "netural; or items 23s or 28s-1 show reumatic event, fre Medical Ever-th at must be rediffied at To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 □ Divorced	Armed Forces?	}	Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 2⊠No	n, Mexican, Puert Specify:	Rican, etc.)	Specify	k, White, etc.			
Maryland 21215-0036 to 2 should be filed within 72 hours att the and Mantal Hyglene. 27 is marked other than "netural", or treumatic event, the Medical Exertal To Be Completed by F	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa kind of work done of	ation during most of wor	kina	16b. Kind of Bu	usiness/Industry			
Mathin 191	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired;)		D-1-	2 9			
121		(st)	Casi	nier	18. Mother's Nan	ne (First, Middle,	Reta				
/land uld be fi Wental H inked ott								-,			
ary shoul	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a		en Marshall ural Route Number, City or Town, State, Zip Code)					
and 2 saith a	Colleen Shiple						Pines,	Md,21811			
Baltimore, permit. Pages 1 ar Department of Hea Important: If them in pringly or othe any four.	20a. Method of Disposition 1 Darial 2 Cremation 3	20b. P	lace of Dispo emetery, crei	sition (Name of matory or other place	9)	Date	20c. Location -	City or Town, State			
Limor Pages Iment of tant: If it	* 4 □Donation 5 □ Other (Spe	ocity) Sa		ary Crem		10-2	Salis	bury, Md.			
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Man Important: If item 27 is marke any nijury or other treumatic.	21. Signature of Fu, anal S., ce Li	flux	U	Name and Addres	uneral		Berlin				
3760, ate be executed he be unial-transit he burial-transit he burial-transit he burial-transit he burial-transit he burial-transit he burial-transit here.	23a. Part. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Approximate Interval Between Onset and Death Value 4 Value 4									
Records, P.O. Box 6876(The law requires that the death certificate be tite has been signed by the attending physicis tage 2 should be detached for use as the but completed by Physician/Medical		d	ideath 3[Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day Year			
Cords, F wrequires that been signed should be det	Part II. Ditter significant condition		ulting in the u	nderlying cause give	en in Part I.	1		nbute to the cause of death? 3 Probably 4 Unknown			
Division of Vital Records, to attending Physicien: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed by						24a. Was autor perfo	med?	Were autopsy findings available brior to completion of cause of leath? □ Yes 2□ No			
/ital					26. Place of Dea		The same of the sa	MANY ANDRIAN			
of Vita Physicien: this certifical director,	1	Hospital: 1 Inpatient 2 I	ER/Outpatier		er: 4 🗆 Nursing H		dence 6 % the	er (Specify)			
/ision Attending r death. sctor: Atten	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year)	Injury	Work	k? Yes 2 □ No						
Division c	3 Suicide 6 Could no determin		ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Numbe wn, State)	er or Rural Route Number,			
Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (Physicien: To the best of my know xeminer: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)			
To th within To th comp	29b. Signature and file of certifier	DR O.		29c. License			_	(Month, Day, Year)			
	30. Name and address of person w	no completed cause of death (Item	n 23a) (Tvna	Print)	72/	6	reptronh	4 68, 2009			
ET 4	Christian D.	bounds, M.D.	106 M	1.1Ford ST	isoite b	os. Sul	15/20-1.	mo 21804			
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa			J. J.	1	•				
Registrar	363 27 200°	T UCT	0 1 200	14 Blocus	V B	Joans)		72			

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland		artment of i			-	giene		3266	6.2
			1. Decedent's Name (First, Middle, I	_ast)	-					2. Date of Dea	ath		3. Time of I	Death
	Physici /Medi		Billie Pap	pas Mani	ion					Month Septemb	er 27	, 2004	11:28	Ам
	Examir		4a. Facility Name (If not institution, g				4b. City, Town,	or Location				unty of Death	1	
			4213 Glenrose St	reet			Kensin	gton			Mor	ntgome	rv	
	Funeral		5. Social Security Number 6		e (In yrs. lasi	birthday)	If Under 1 Year	If Under	r 24 Hrs.	B. Date of Birt. (Month, Day		9. Birth	place (State or	Foreign
	Director		216-40-8996	1 ☐ M 2 🔀 F	83	Yrs.	Months Days	Hours	Min.	4ay 18	1921	Vi	ntry) rginia	
	p ,		Usual Residence of Decedent											
	aryla shov	_	10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City	
	8a-f	cto		gomery	Kens	ingto	on						1 X Yes	2∐No
	or 2	E	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow ta Madical Exertire must be rollited at	Funeral Director	4213 Glenrose St					20895				S.A.		
	tems	une	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of I f Yes, specify Cub	Hispanic Or an, Mexica	rigin? (Spec in, Puerto R	ify Yes or No- ican, etc.)	14.	Race - Ameri Black, White,		
9	s afte	by F	1 Never Married 2 Married	If Yes, Give	1744	.	1 ☐ Yes 21≦ No					ecify: Whi		
21215-0036	hour fural	p p	3 XWidowed 4 Divorced	Year or Dates:	1945		1-1-11		_					
5	n 72	Completed	15. Decedent's (Specify only highest of		'	(Give	lent's Usual Occu kind of work done DO NOT use retire	dunna mos	st of working	9	16b. Kind o	of Business/Ir	ndustry	
72	withi ene.	щć	Elementary/Secondary (0-12)	College (1-4or 5	5+)		rse	, d _j			Monta	omo ru	General	Uoan
0 0	filed Hygi ther int, I	ပ္	17. Father's Name (First, Middle, La.				150	18. Moth	er's Name	First, Middle,			General	.nosp
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23e or 28e-f ehow among young other traumatic event, if a Modical Examination and page.	o Be	James Pappas							Kouts		,,,,,,		
<u>-</u>	shoul nd Me mark	ပ	19a. Informant's Name/Relationship	(Type, Print)		19b Mailin	g Address (Street					um Stato 7	Codo)	
<u>≅</u>	od 2 stranger tranger		William Manion				Radnor R						_	
a)	Hea Hea tem		20a. Method of Disposition	/ 5011			sition (Name of natory or other pla		Da	- pain	-	1 2081 on - City or To		
Baltimore,	ages in of the state of the sta		1 ⊠ Burial 2 ☐ Cremation 3					ce)	Octob	er.1.				
Ē	artme ortan		'4 Donation 5 Other (Specify) Gate of Heaven Cem. October 4, Silver Spring, Md. 21. Signature of Fundal September 1 September 2. Name and Address of Facility DeVol Funeral Home											
B	Depril Impo		100	7//									D 0 00	007
			23a. Part1. Enter the disease, or co	molications that causes	the death [222 Wisc					ngton,		J0 /
			shock, or heart failure. List on Immediate Cause (Final	y one cause on each lin	ne.	1 +				,			Approximate Interval Betwee Onset and De	een eath
	Physician /Medical		disease or condition resulting in death)		clero	110	cardio	vasc	ular	dise	ase			
	Examiner		Due to (or as a consequence of): Hubertension											
		er	Sequentially liet conditions if any, leading to immediate											
	ted	n n	if any, leading to immediate cause. Enter Underlying Cause (Disease or right):											
	xecu and	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):											
8760,	ficate be executed physician and s the burial-transit	la la												
281	ficate phy s the	edlcal												
X	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							234	Date of delive	an.	
Вох	atter after	clar	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pregnance Other (specify)	У				Month	Day Ye	ar
o.	the c y the ichec	ys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			/-							
Ť	that ned b		Part II. Other significant conditions	contributing to death be	ut not resultin	g in the un	derlying cause giv	en in Part I		23e. Did tot	pacco use c	ontribute to the	ne cause of dea	ath?
Records,	uires sign	d by								1 □ Ye	s 2 No	3 Prob	ably 4 🗆 Un	known
2	w red beei	ete								24a. Was a	24	Ib 18/222 2142		-11-61-
Re	The lay cate has page 2	Completed								autops	У	prior to con death?	psy findings av mpletion of cau	ise of
_		e Co	25. Was case referred to medical							1 ☐ Yes 2	2,AQ No	1 ☐ Yes	2 No	
Vital		o Be	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital:			20 pos Ott	or		Check onl on	-,			
o	Phys raldi	\vdash	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatie		Outpatient D. Time of	3 □ DOA 28c. Injur	4 LINU		5 Reside			y)	
0	ding h. After fune	to	1 Natural 5 Pending	(Month, Day		Injury	Wor	k? Yes 2 □		J. Describe no	w injury occ	Juried		
Division of	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not	be One Diese of leis	ırv - At home	farm stre		100 20		Location (St	reet and Nu	mber or Pura	l Route Numbe	
2	or Attending P after death. I Director: After t d in by the funera	Certification;	4 Homicide determine	building, etc	. (Specify)	10,111, 0110	ot, ractory, office		201	City or Towr	, State)	moer or riura	r Houle realfibe	4,
	spita cours reral filled		29a. Certifier 1 ☐ Certifying F	Physician: To the best of	of my knowled	ige, death	occurred at the tir	ne date an	d place, and	d due to the ca	uso(s) and	manner ac el	atod	
	24 h 24 h e Fur etely	edical	(Check only 2 Medical Execute)	miner: On the basis of and manner sta	examination	and/or inv	estigation, in my o	pinion, dea	th occurred	at the time, da	ate and plac	e, and due to	the cause(s)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Me	29b. Signature and title of certifier	^	,		29c. Licens	e number		2:	9d. Date sig	ned (Month, i	Day, Year)	
			Dochitais T	Toma los	Man.	ma	9	0510	9/0	2	Pento	mhon	27.01	204
	5+1		30. Name and address of person who	o completed cause of d	eath (Item 22	a) (Tues F	Print)	1			Tole	יושכוי	1 20	v 7
			Patricia Tomas	to Nau 11	119 K	OC.	villa D	to 1	6-10	2. Room	Fuill	e mr	1000	50
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	12	111011	10	- 1-1	1100	10/1/6	71110	2000	
	Registr		SEP 29 2	004	مصرر	B	spork.	2/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:25 PMM McClelland 25, Dona1d Roberts September 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 27267 Fairmount Road Upper Fairmount Somerset If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Illinois Director 364-30-8501 73 12-13-1930 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, It a Medical Examinar must be notified at 1 Yes 2 □ No MD Somerset Upper Fairmount Direct 10e Street and Number 10g. Citizen of What Country? 10f, Zip Code 27267 Fairmount Road 21867 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Curator Museum 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Donald Roderick McClelland Winifred Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27267 Fairmount Road, Upper Fairmount, MD 21867 pate 20c. Location - City or Town, State Janet McClelland/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 09-29-2004 Salisbury, Maryland Signature of Fune at Service icensee 22. Name and Address of Facility Hinman Funeral Home 23a. Part1. Enter the di shock, or heart fa M00295 11673 Somerset Ave., Princess Anne, MD 21853 or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line.

a. Multiple Myelona. Approximate Interval Between Onset and Death lure. List only one cau Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by (Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 □Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has certificate 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examinec? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 sidence 6 Other (Specify) 1 Tes Certification: To this 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Dire 10 Contifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rm OREALL MY

DHMH 17 Rev 1/2001

State Registrar OAUD (OZLAL)
31. Date filed (Month, Day, Year)

ORIGINAL

0.50x

32. Registrar's Signature

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Margaret Odia Mentges September 29. 2004 7:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6304 Long Beach Drive St. Leonard Calvert County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 61 578-56-4415 Director July 27, 1943 Washington, D.C Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10a. State 10b County 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Calvert County St. Leonard MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20685 U.S.A. Funeral 6304 Long Beach Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 'natural', or Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked of Margaret Page Brown George Hayes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 266, Saint Leonard, Maryland 20685 Louis Mentges (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition October 1. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 2004 Fort Lincoln Cemetery 21. Signature of Funeral Septice Linenses 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. . v 8125 Southern Maryland Blvd., Owings, MD 20736 Mickeel W. Lee les 23a. Part1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition WITHER STASUS **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 2 No Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No Certification: To SIL 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a To the Funeral I 29a. Certifier 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of H00377287413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen P. Cafferty, D.O., 225 Town Square Drive, Suite 2, Lusby, Maryland 20657 31. Date filed (Month, Day, Year) 32. Registres s Signature State 2004 ▶ seen & specke Registrar

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			1 - For State Registrar AMEND ITEM	State of Maryla				, ,	. W. Ch. ob. 1					
	81		Decedent's Name (First, Middle, Last		b Gose	10/147 04	Jun	2. Date of Dea		3. Time of Death				
ı	Physici /Medi		Anthony Paul	Muscia				Septemb	er 24, 20	oo4 7:00 a M				
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of D					
			Sligo Creek Nurs: 5. Social Security Number 6. Se		s. last birthday)	Takoma F	ark If Under 24 Hrs.	8. Date of Birth	Montgor					
Ш	Funeral Director		210-01-2930	©M 2□F 87	Yrs.	Months Days	Hours Min.	(Month, Day	Year) 9.	Birthplace (State or Foreign Country) ttsburgh, PA				
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits				
	with the Maryland a or 28a-f show	to	Maryland Prince G		Hyatts					1 ⊠Yes 2 □ No				
	ith the Mi or 28a-f	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?				
	death wi		6000 42nd Avenu	e, Apt 303		20	781		USA					
396	or Ite	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No 19 If Yes, Give Year or Dates: 194	939-	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		merican Indian, /hite, etc. White				
2-0	72 hours "naturel",	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupa	ition		16b. Kind of Busine	ess/Industry				
121	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done a DO NOT use retired, enance Su			· · · · · ·	TT .				
d 2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		Mainte	enance su		ne (First, Middle, M		University				
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. Fis marked other then "raumatic event, the Mad	To Be	Joseph Muscia					a Di Dome	,					
lary	ges 1 and 2 should t of Health and Men if item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (7			ng Address (Street a	nd Number or Ru	ral Route Number	City or Town, Stat					
€, €	l and lealth im 27		Carol J. Muscia -	-		42nd Ave	enue #30:	The state of the s						
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 le eny injury or other trat		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cren	sition (Name of natory or other place Ltan Crema			20c. Location - City Alexandri					
Ball	permit Depart Import eny in		21. Signature of Funeral Service Licent	1013	73		imore Av	enue, Hy		ome, P.A. , MD 20781				
N.	Physician		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Lung Disease											
	/Medical Examiner		resulting in death)	Due to (or as a conse										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury	b. Due to (or as a conse	quence of):									
	acuted and transit	Examiner	triat initiated events	c										
68760,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):									
687	ficate physics the	edical		d										
.O. Box	attendir for use	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year				
٣.	res that the deigned by the be detached	by Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the un	iderlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?				
Records,	w requires been sigi should be	ed b	Coronary Artery	Disease				12 <u>C</u> Ye	s 2 No 3	Probably 4 Unknown				
eco	has been ge 2 shoul	Completed						24a. Was an		autopsy findings available				
	: The cate h page	Соп						autopsy perform 1 Tyes 2	ed? death	o completion of cause of ? es 2∑ No				
Viital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				h (Check only one						
of		٦.	1 ☐ Yes 2 ☒ No ☐ 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of		+M Indianing Inc	ome 5 Resider	nce 6 Other (Sp	pecify)				
ion	ktending death. ctor: Afte y the fune	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work? M 1 \(\sum Y\)	es 2 No	200. Describe no	williary occurred					
Division	ire ire	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,				
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certifier 1⊠ Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the car red at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)				
	To the To the comp	×	29b. Signature and title of certifier	00	1	29c. License	number	29	d. Date signed (Mo.	nth, Day, Year)				
)			1 DIS	DIO >	81	D45660)	8	September	24, 2004				
nf	(4)		30. Name an address o person who con Dpinder Singh, M.			*	Suito 12	/ Part	Ma1 -	1 20715				
	Sta	te.	31. Date filed (Month, Day, Year)	D. 14300 Ga1 Registrar's Sign	ature		ource 124	+, bowle,	maryland	1 20/15				
	Registra	100	SEP 2 8 2004	French	· Anna	K,								

DHMH 17 Rev 1/2001

			1 - For State Registra AVEND#3perMD10/	State of M 4/04,BMW,M	Marylan bCb		artmen rtificate			ınd M		iene	in li	30666
	Physic	ian	1. Decedent's Name (First, Middle, Last)								2. Date of Deat Month	h Day	Yeer	3. Time of Death
	/Medi		Francisca I. Noo	guera							Septembe		2004	10:54 - 10:54
	Exami	ner	4a. Facility Name (If not institution, give		r)		4b. City,	Town, or	Location of				inty of Deati	
			10302 Calumet Dr						Spri			Moi	ntgome	ery
	Funeral		5. Social Security Number 6. Sec	7. A		last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Dec . 28,	Year)	9. Birth	nplace (State or Foreign untry)
	Director		210-30-3660		6	5 Yrs.					Dec. 28,	1938	Me	xíco
	and		Usual Residence of Decedent 10a. State 10b. County		10c, City	/, Town or Lo	cation							10d. Inside City Limits
	/any	ō	Marcaland											1 ☐ Yes 2 🖾 No
	28a-	ect	Maryland Montgome	ry	S	îlver								
	with	ä	10302 Calumet Driv				10f. Zip				11	lg. Citizen	of What Cor	untry?
	eath	by Funeral Director		12. Was Deceden	A Francis III			0901					KÍCO	
	Item	Ë	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Amed Forces	?	5. 13. 1	f Yes, spec	fy Cubar	n, Mexican,	Puerto F	cify Yes or No- Rican, etc.)		Race - Amer Black, White	
36	I', or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	_		Yes 2	!□ No	Specify M	lexic	an	Spe	city: Wh:	ite
ŏ	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-1 show he Madical Examinar must be notified at		15. Decedent's Edu		· 	16a. Deced	lent's Usua	l Occupa	tion			Sh Kind of	Business/I	aduatas
21215-0036	in 7	Completed	(Specify only highest grade			(Give life.	kind of wor	k done d e retired)	uring most	of workin	g	db. Kind of	Dusiness/i	ndustry
7	iene r tha	Eo	Elementary/Secondary (0-12)	College (1-4or	7 5+)		memak					Otot	n Home	_
	12 should be filed within h and Mental Hygiene. 7 is marked other than "reumatic avent, the Med	Be C	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle, N			=
Maryland	id be ental ked ic av	To B	Luis Medina						Aga	nita	Zumarr	aga M	artin	
ΞŽ	shou nd M mar	-	19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Mailin	a Address	(Street a						in Codel
Š	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23e or 28a-1 show other treumatic avent, The Madical Examinar must be notified at		Hugo Reno Noguera	/ Unabas	a									
ē,	tam 27 intention		20a. Method of Disposition	/ nuspan	20b. Pl	ace of Dispo	sition <i>(Nam</i>	e or		Da	ate 2	Oc. Locatio	g , MD n - City or T	20901 own, State
no	Pages nent of I			emoval from State	^e Me	etropo.	litan	her place	9) S		ber 29,			
Baltimore,	Department Pag Department Important: I any injury once.	H	1 Burial 2 Cremation 3 Removal from State Crematory or other place) September 29, Alexandria, Virginia Crematory 2004 Alexandria, Virginia Signature of Funeral Service Licensee 22, Name and Address of Facility Francis J. Collins Funeral Home Inc.											Virginia
Ba	permit. Departn Imports any inju	Hugo Rene Noguera/ Husband 20a. Method of Disposition 1									W, Silv	liver spring, MD 2090		
	/Medical Examiner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a conseque	ence of):	(a.	nev	\					Interval Between Onset and Death
O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as	e of pregnar	ncy death 3	Ectopic pre Other <i>(spe</i>						Date of deliv Month	ery Day Year
rds, P	es pe	by	Part II. Other significant conditions con	tributing to death	but not resul	Iting in the un	derlying ca	use giver	n in Part I.			cco use co	ntribute to t	he cause of death?
Hec	The law ate has b page 2 sl	e Completed	26 Was and other days of the last								24a. Was an autopsy perform	ed? ¥No	death?	opsy findings available impletion of cause of 2 No
		o Be	25. Was case referred to medical examiner?	ospital:				Other			Check only one		-	
	ing After une	ertification; To	1 ☐ Yes 2 🔀 No	28a. Date of Inj (Month, Da	ury :	ER/Outpatient 28b. Time of Injury		c. Injury a	4 LI Nurs	28	e 5 A Residen d. Describe hov		ther (Specil urred	ý)
	F 2 2 7	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	ijury - At hon tc. <i>(Specify)</i>		et, factory,	office		28	f. Location (Stre City or Town,	et and Nun State)	nber or Rura	al Route Number,
	To the Hospital o within 24 hours at To tha Funaral D completely filled in	edical	29a. Certifier (Check only one) ↑ Certifying Phys 2 ☐ Medicel Exeminates	ician: To the best er: On the basis of and manner st	or examination	rledge, death on and/or inv	occurred at estigation, i	t the time	, date and nion, death	place, an occurred	d due to the cau I at the time, dat	se(s) and n e and place	nanner as s e, and due to	tated. the cause(s)
		W	29b. Signature and title of certifier	4 NI	desc	17/		License	number 8 7 9	7 >	290		ned (Month.	
	3		30. Name and address of person who cou				Print)							
200	Sta Registr		Manuel Hidalgo Med 31. Date filed (Month, Day, Year)	32. Regist	165 rar's Signatu	O Orle	Apor	tree	et, #1	Lm88,	<u>Balti</u> m	ore,	MD 21	231-1000

			1 - For State Registrar	State of Marylan		artmen rtificat			d Mental	Hygiene		00000		
			Decedent's Name (First, Middle, Last	0					2. Date of	of Death	. 004	3. Time of Death		
	Physici /Medic		MARY M.	OLAUSSEN					SEPT	EMBER	, žöő	4 8:00 A M		
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of C	Death		County of Dear			
			18006 VINTAGE RIVE			OLNE		Millodes CA	Hea a a		MONTGOM			
	Funeral Director		023-12-1132	7. Age (In yrs. 81	Yrs.	If Under Months	Days	Hours I	Min. B. Date of (Mont) JULY	18, 1	923 MAS	thplace (State or Foreign SACHUSETTS		
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits		
	ath with the Marylan 23a or 28a-f show	ţō	MARYLAND MONTGOME	ERY OL	NEY							1 ☐ Yes 2 ☐ No		
	r 28a	lrec	10e. Street and Number	2222		10f. Zip	Code			10g. Cit	izen of What Co	ountry?		
	15 wit	alD	18006 VINTAGE RIVE				208				ED STAT			
36	ritemer ritem	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	.S. 13. Y	Was Deced If Yes, spec 1 ☐ Yes		spanic Origin n, Mexican, P Specify:	? (Specify Yes o Puerto Rican, etc	or No-	14. Race - Ame Black, Whit Specify:			
Ş	in 72 hours a n "natural", o		15. Decedent's Edi		16a. Dece	dent's Usua	al Occupa	tion	(advia a	16b. K	ind of Business	Industry		
21215-0036	- 22	Completed	(Specify only highest grad	College (1-4or 5+)	life. I	DO NOT u	se retired)					2) 2 (E) M		
		Соп	12		OFFIC	E ADM		TRATOR			S. GOVE	RNMENT		
Ind	0 = 0 >	Be	17. Father's Name (First, Middle, Last)	TOGA				18. Mother's		a (First, Middle, Maiden Surname) CAMAIONI				
<u>S</u>	2 should be and Mental is marked c	ပ		LOSA	10b Mailie	a Addross	/Stroot 2			ral Route Number, City or Town, State, Zip Code)				
Maryland	i. Pages 1 and 2 should b thent of Health and Ments ritant: If item 27 is marked njury or other traumatics.		19a. Informant's Name/Relationship (T			-			TERRACE					
	1 and Health tem 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Nar	ne of	1	Date	-	ocation - City or			
<u></u>	Pages nent of int: If it		1 ☐ Burial 2 🕅 Cremation 3 🖾 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	cemetery, crer FIONAL	-			/28/2004	FALI	LS CHURC	CH, VIRGINIA		
Baltimore,	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Service Licens		DA DA	Name and NZANS	d Address	s of Facility OLDBER	RG MEMOR	IAL CH	APELS,	INC. 0852		
2	JENS.		23a. Part1. Enter the disease, or comp	ications that caused the deat							,	Approximate Interval Between		
	Pnysician		shock, or heart failure) List only one cause on each line. Immediate Cause (Fin disease or condition a PULMONARY HYPERTENSION 33 WEEK											
	/Medical		resulting in death)	Due to (or as a conseq		NOTON						33 WEEKS		
	Examiner		Sequentially list conditions.	b										
	₽ ₩	iner	if any, leading to immediate	Due to (or as a conseq	uence of):									
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	mence of).									
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687	phys phys s the	dicai		d										
Box (death certificate e attending phys of for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna							23d. Date of del	ivery		
ă	death a atter	cia	in the past 12 months? 1 □ Yes 2 XNo	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pr Other (sp				_	Month	Day Year		
O.	by the de	hys	9 Unknown	9□ Unknown										
Records, P	as this	þ	Part II. Other significant conditions co	intributing to death but not res	ulting in the u	nderlying o	ause give	n in Part I.		Did tobacco t 1 ☐ Yes 2		o the cause of death? robably 4 X Unknown		
00	aw requirats been si	Completed								Was an	24b. Were au	utopsy findings available completion of cause of		
Re	The la ate ha page 2	mo								performed?	death?	2 X No		
Vital		Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check of					
>	S 0 =	Tof	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien				ng Home 5 🔀	Residence	6 □Other (Spe	cify)		
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work			ribe how injur	y occurred			
Division	e a co	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M		′es 2 □ No		on /Street or	d Number or D	ural Route Number,		
Σ	or Attendated death Director:	ili	4 Homicide determined	28e. Place of Injury · At he building, etc. (Specif	ome, tarm, str fy)	eet, factor	y, affice			r Town, State		Irai Houte Number,		
J	To the Hospitel or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical Ce		ysician: To the best of my kno inner: On the basis of examina and manner stated.										
	To the within 2	Med	29b. Signature and title of certifier			290	c. License	number		29d. Da	te signed (Mont	h, Day, Year)		
)	⊢ s ⊢ ŏ		1 Chusto	el arms		i	D39	793		SEF	TEMBER	27, 2004		
	2		30. Name and address of person who o	completed cause of death (Iter	n 23a) (Type,	Print)								
			CHRISTOPHER J. MA				HILIF	P DRIVI	E, #207	OLNEY	, MD 2	20832		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	1	0	,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 10, 2004 11:00am^M Robert Levi Price /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Frederick 516 Magnolia Avenue 8. Date of Birth (Month, Day, May 8, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1₹M 2□F 94 Yrs 216-14-5106 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event. The Medical Examinar must be notified at once. 10a. State 10b. County 1X Yes 2 □ No Maryland Frederick Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 Magnolia Avenue U.S.A. 21701 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes XX No Baltimore, Maryland 21215-0036 White ð 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President/Manager Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Vernon Price Mae Wilt Lucy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 516 Mangolia Ave., Frederick, MD 21701 Carol Ann Parks, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Washington 2 Cremation 3 Removal from State 20c. Location - City or Town, State Mount Olivet Cemetery Oct. 13, 2004 Frederick, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland M00255 23a. Part1. Enter the disease, or complications that gaused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) emmonia consequence of **Physician** /Medical Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner anding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No õ Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner Leath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by Hospital filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel To the 29b. Signature and title of certifier cause of death-(Item 23a) (Type, Print) 30. Name and address of person 22. Registrar's Signature filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Casson		ae	PORTNER 1 - State Unpend Item Registrar	Star 23a, p	te of Ma	aryland 27 pe	d/Depa	artmer 1836 Hificat	t of H 10-2 e of i	lealth a	and M tas	ental Hy	gien Reg. N	e 2004	32669
			Decedent's Name (First, Middle, L.									2. Date of De	ath		3. Time of Death
	Physicia /Medic		Cassondra Gray PORTNER October 5, 2004 10											10:00 A ^M	
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Court									c. County of Deat			
~			801 Orchard Man	or Dr	ive			1		sboro				Washir	ngton
5	Funeral			Sex 1 ☐ M 2			as <i>t birthday)</i> Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th i <i>y, Year</i>	9. Birtl	hplace (State or Foreign untry)
3	Director		226-02-2931 Usual Residence of Decedent			46	115.					Jan. 5	, 1	958 Vir	ginia
	/land		10a. State 10b. County			10c. City	, Town or Lo	ocation							10d. Inside City Limits
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The marked other then "naturel", or Items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	ţoţ	Maryland Washi	ngton			Boons	sboro							1X Yes 2 □ No
	th the	Director	10e. Street and Number		•			10f. Zip	Code				10g. C	itizen of What Co	untry?
	th wil	aiD	801 Orchard Man	or Dr	ive				21	713				USA	
	r dea	Funeral	11. Marital Status	Arm	s Decedent 8 ned Forces?		S. 13.	Was Dece	dent of H	ispanic Ori in, Mexicar	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Ame Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	If Ye	Yes 2∭XN es,Give	lo		1 ☐ Yes						Specify:	white
8	hour	ed b	15. Decedent's		ar or Dates:		16a. Dece	dent's Hen	al Occup	ation			16b k	Kind of Business/	
7.	in 72 n "na Nedic	piet	(Specify only highest g	rade compi			(Give	kind of wo	rk done d	during mos.	t of working	ng	100. 7	Viria or Businessy	ridustry
212	d with	Completed	Elementary/Secondary (0-12)	0	lege (1-4or 5	+)	cust	omer	ser	vice	repre	esentat	ive	cred	it card
P	al Hyg I othe vent,	Bec	17. Father's Name (First, Middle, Las	•						18. Mothe	er's Name	(First, Middle,	Maide	n Sumame)	
<u>Za</u>	Menta Menta arked	To	Maynard Robinet	te			_			В	etty	un	kno	wn	
Maryland 21215-0036	2 shc and Is m		19a, Informant's Name/Relationship		-								-	or Town, State, Z	
2	and Health m 27		Harry E. Portne	r - h	usband		305 E	3 Nort	th Co	oloni.				town, Md	
0.0	ges 1 If of H or of		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		I from State		ace of Dispo					ate		ocation - City or	
Baltimore,	t. Pa rtmer rtent:		'4 □ Donation 5 □ Other (Spec		-	Lec	lar La								, Maryland
Ba	permit. Pages 1 Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service Lic	M	7					s of Facilit	1.1.1			ERAL HOM	
			23a. Part1. Enter the disease, or co	mplications	that caused	the death								m, Md.	21/40 Approximate
	Dhiminian		snock, or neart failure. List on Immediate Cause (Final	ry one caus	e on each lin	10.									Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	g	ue to (or as a			oscie.	LOLI	c Car	атоля	ascular	דע	sease	
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	ocuted nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.											
90,	ate be executed hysician and he buriat-transit	EX	resulting in death) Last	D	ue to (or as a	a consequ	ence of):								
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9 ×	uires that the death certifics signed by the attending ph d be detached for use as t	Physician/Med	IF FEMALE:	23c If ve	es, outcome	of pregnar	acv.								
Bo	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 🗆	Live birth Pregnant at	2 Fetal	death 3	Ectopic pr Other (sp						23d. Date of deli- Month	Day Year
Ö	the de y the ched	ysic	1 □ Yes 2 □ No 9 ☑ Unknown		Unknown	uno or de	a 5_	J Other (Sp	ecny)						
	that ned b		Part II. Other significant conditions	contributin	g to death bu	ut not resu	lting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco	use contribute to	the cause of death?
rds	quires n sign	d be	Diabetes Mellitus	3								101	res 2	□No 3□Pro	bably 4 Unknown
Ö	s been si	olete										24a. Was		24b. Were aut	opsy findings available
Re	ding Physicien: The lav n. After this certificate has funeral director, page 2	Completed by											rmed?	death?	ompletion of cause of 2□ No
ital	rtifica	Bec	25. Was case referred to medical							26. Place	of Death	(Check only o		12765	2 140
>	nysic nis ce direc	ToE	examiner? 1 □XYes 2 □ No	Hospital:	1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatier	nt 3 DC	Othe	9r: 4 □ Nu	rsing Hon	ne 5□Resid	dence	6 ☆ Other (Spec	MAT scene
0 [ng Pt		27. Manner of Death 1 Natural 5 ☐ Pending	28a.	Date of Injur (Month, Day	Year)	28b. Time of Injury	1 2	8c. Injury Work	at		8d. Describe l			
<u>s</u>	death. ctor: A y the fu	cati	2 Accident investigati 3 Suicide 6 Could not	he -				М	1 🗆 1	Yes 2 1	-				
Division of Vital Records,	or Attending Physicien: The law requires that the death certifics Differ death. Director: After this certificate has been signed by the attending phen by the tuneral director, page 2 should be detached for use as it in by the tuneral director, page 2.	Certification:	4 Homicide determine	d 289.	Place of Inju building, etc	iry - At hor :. <i>(Specify)</i>	me, farm, str)	eet, factory	, office		2	8f. Location (5 City or Tox	Street ai vn, State	nd Number or Rui e)	al Route Number,
	pitel ours a erel (29a. Certifier 1 ☐ Certifying I	Physician:	To the best of	of my know	uladaa daati	h 000		a data as	d alasa a	and along to the)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medicel Ex	aminer: On	the basis of	examinati	on and/or in	vestigation	, in my op	oinion, deal	th occurre	d at the time,	date an) and manner as d place, and due	stated. to the cause(s)
	vithin Vithin To th	Me	29b. Signature and title of certifier					290	. License	number			29d. Da	ite signed (Month	, Day, Year)
			> anestz	· .					OCM	Œ		(Octo	ber 6, 2	2004
			30. Name and address of person wh	o completed		eath (Item	23a) (Type, 1	Print) Pe	enn S	treet	c, Ba	ltimor	e, M	Maryland	21201
	Sta Registr		31. Date filed (Month, Day, Year)	14.	32 Registra		Lg .	Spor	KS	ŀ					

State of Maryland / Department of Health and Mental Hygiene

				State of Ivid	arylanu i	•	ificate of	Death		Reg. No.2		326	70	
			1. Decedent's Name (First, Middle, Last,						2. Dete of Death Month Day Year 3. Time of Death					
	Physicia /Medic		Donald Wildred Re	eynolds						ber 28,		12:45	AM	
	Examin		4a Facility Name (If not institution, give	street and number)				4b. City, Town, or	Location of Death	4c. County				
4			Julia Manor Health		nter			Hagerst		Washi	ngton	Count	v	
	Funeral		5. Social Security Number 6. Sec	Months Da			If Under 1 Year Months Days			h y, Yea <i>r)</i>	9. Birthpla Countr	ce (State or i	Foreign	
120	Director		170-24-8790	XM ZUF	75	Yrs.			April 6	1929	Penns	sylvan.	<u>ia</u>	
	p .	-	Usuel Residence of Decedent 10a. State 10b. County		10c City T	own or Loca	ation				10	d. Inside City	Limite	
	short s	<u> </u>												
	the N	5	Maryland Washingto	on	H	agerst	10f. Zip Code			10g. Citizen of \	Mhat County	1 ☐ Yes 2		
	With the second	ᄒ	11719 Robinwood I	mitro			21742			U.S.A		y :		
	ter death with the Maryler flems 23a or 28e-f show free intel be notified at	era		12. Was Decedent (Ever in U.S.	13 Wa		Hispanic Origin? (5	Specify Yes or No-		ce - Americar	n Indian.		
Maryland 21215-0020	within 72 hours after death with the Marylend ene. than "natural", or items 23a or 28e-f show the Medicel Examiner must be motified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates:			Yes, specify Cub	Hispanic Origin? (s ean, Mexican, Puer Specify:	to Rican, etc.)	Specify	ck, White, et whit	c.		
50	72 hours natural, dical Exe	<u>8</u>	15. Decedent's Edu (Specify only highest grade	cation	1	6a. Deceder	nt's Usuel Occup	petion during most of wo	rkina	16b. Kind of B	usiness/Indu	stry		
21	E	힐	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DC	NOT use retire	nd)	,,,,,,,					
2		S	12			Machi	ınıst	1				cturing	g	
pu	生工事を	To Be	17. Father's Name (First, Middle, Last)						me (First, Middle,		10)			
Zla	ould be Mental Mrked o	ဥ	Amos W. Reynolds						. Bigler					
a l	2 short and less min		19a. Informant's Name/Relationship (Ty					t and Number or R				ŕ		
	s 1 end f Health ttem 27	-	Pamela K. Decker 20a. Method of Disposition	(Daughter		106 I	Tairbroc	ok Drive	Furnace Date	Pennsyl 20c. Location -				
Baltimore,	60 C L		1 ☐ Burial 2 🖾 Cremation 3 ☐ R	emoval from State	ceme	etery, crema	tory or other pla	1			•			
ţ	Demit. Peg Department Mportant: If any injury o		4 Donetion 5 Other (Specify)		Smit		g Cremat		9/30/04	Smiths	burg M	Maryla:	nd	
Ba	Depa Impo any i		21. Signature of Euneral Service License	Paul	24 3	133	31 Easte	ern Blvd.	uglas A. N. Hage	fiery : rstown,	Funera Mary]	land 2	e 1 74 2	
-14			23a. Pert Enter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each lir	the death. E	Do not enter	the mode of dyi	ng, such as cardia	c or respiratory ar	rest,	i Ir	Approximate Interval Between Onset and De		
	Physician /Medical		Immediate Cause (Final disease or condition	Ble	adde	le_	Can	eer				14	74 01	
7	Examiner	e	resulting in death)		Due to (or as	a conseque								
	cuted nd trensit	Examiner	Sequentially list conditions,)	Due to (or as	e conseque	ence of):							
68760,	rificate be executed g physician end es the buriel-trensit	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								1			
687	= 000	8	resulting in death) Last		Due to (or as	a conseque	nce of):							
Box	the death cer y the attendin ached for use		d											
Ξ.	deat he att ed fo	응	Part II. Other significant conditiona con	tributing to death bu	at not resultin	g in the und	erlying cause giv	ven in Part I.	23b. Did to	obacco use co	ntribute to t	he cause of	death?	
P.O.	es that the death cer igned by the attendin be detached for use	Physician/M							101	/es 2□ No	3 Proba	bly 4 Du	nknown	
	es th igner	ል							_					
ord	w requires that been signed b should be dete	ह							24a. Was a perfor	an autopsy med?	availa	autopsy find able prior to		
Records,	has be	Completed									of de	pletion of cau ath?	150	
	The la	် ဂ							1 🗆 Y	es 2No	10	Yes 2□ N	0	
/ita	certifica rector, p	a B	25. Was case referred to medical examiner?				100		ath (Check only o	ne)				
of Vital	Ø 0 10	욘	1 163 2010	ospital: 1 Inpatie		/Outpatient	3□ DOA Ott	4 D (Nursing F	lome 5 ☐ Resid					
	Ing P	e o	27. Manner of Deeth ↑ Anaturel 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28	b. Time of Injury	28c. Inju Wo M 1 □	ryat rk?]Yes 2 □No	28d. Describe h	ow injury occuri	ed			
isi	Attending if death. actor: After by the fune	Cat	2 ^f Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Inju	ırv - At home	farm stree		1163 2 1140	28f. Location (S	treet and Numb	er or Rural f	Route Numbe	er .	
27. Manner of Deeth The Part of										0. 0	10010 / 10/100			
	Hospi 14 hou Funer tely fill	edical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of er: On the basis of and manner sta	examination	dge, death o and/or inves	ccurred at the til stigation, in my o	me, date end place opinion, death occu	e, and due to the corred at the time, co	ause(s) and me date and place, a	nner as stat and due to th	ed. ne cause(s)		
	within 2 To the comple	M	29b. Signature and title of certifier				29c. Licens		2	29d. Date signed	d (Month, De	iy, Year)		
			70		-		03	2323		9/29	154			
		1	30. Name and address of person who co	mpleted cause of de	ath (Item 23	a) (Type, Pr			16 300	0 016	11/2			
			AHIIII) a	JHJCC1	A 1	120	OPHL	-CTHI	UQ IN IN	121	170			
	Stat		SEP 3 0 2	32. Registra	r's Signature	4. de	ele							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Oct 4. 2004 8:45 AM Root Arthur 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegany 214 Cole Street Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sep 5, 1940 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours Min 1**√** M 2□ F 64 213-40-3741 Yrs. Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1 ☐Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 109 Reynolds Street 21502 USA 12. Was Decedent Ever in U.S. Amed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1958-1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white 3 ☐ Widowed 4 Ď Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) laborer railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Lena Catherine Ambrose James Root 9a. Informant's Name/Relationship *(Type, Print)* **Marlene Bishop** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Monroe Street Cumberland MD 21502 sister 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Rocky Gap Veterans Cemetery 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/2004 **Flintstone** MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. NanScarbent Punellal Home, P.A 108 Virginia Avenue; Cumberland, MD 21502 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or andition resulting in eath) UNK. YRS. CARCINOMA OF THE LUNG Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 2 Yes 2 \(\subseteq \) No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death

Examiner attending physician and for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed signed I certificate Be this After this funeral of Certification:

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

r then "neturel", or Items 23e or 28e-f show the Medical Examiner must be notified at

other

Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 Is marked ott

permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 Is
any injury or other trau

Physician

Examiner

/Medical

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

2

Physician/Medical þ Completed

Director

Vital Records, P.O. Box 68760,

within 24 hours at To the Funerel D

filled in by

State

1 Natural

2 Accident

4 - Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

Paul Snow M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending

investigation

100

6 Could not be



124 W. 3rd Street Cumberland MD 21502 32. Figistrer's Signature

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D09157

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

10-4-04

OCT 1 4 2004

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:54 PM JOSEPH IRVING ROYAL October 6,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1(**X**M 2□ F Director 216-22-7890 Maryland July 20, Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic avant, the Modical Examiner must be notified at 1 X Yes 2 ☐ No Completed by Funeral Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1301 Pinewood Drive 21701 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1945 If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: 3 Widowed 4 Divorced 1946 Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) U.S. Postal Service Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be itam 27 Is markad o 2 W.C. Royal Nellie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Nancy J. Royal/Wife 1301 Pinewood Drive, Frederick, Maryland, 21701 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State *****0 1 Removal from State
1 Donation 5 Other (Specify) ŏ permit. Page Department of Important: If any injury or once. Mt. Olivet Cemetery 10/9/2004 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street Kyan 7 ⊆ Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 ongestive Days /Medical Due to (or as a consequence of): **Examiner** DISCOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oronan Due to (or as a consequence by Physician/Medical Examiner burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) igned by the a be detached f P.0. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ereprovascular 1 Yes 2 X No 3 ☐ Probably 4 ☐Unknown director, page 2 should Be Completed fib inlution 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy typestention.

25. Was fase referred to medical examiner? 1 Yes Viial 26. Place of Death (Check only one) Other: Hospital: Inpatient 1 Tes No Certification; To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ō this the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred Division Natural 5 Pending investigation after death. Diractor: A 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To tha Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Shah Hiren, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) m) honson 32. Registra 31. Date filed (Month, Day, Year) State Registrar OCT 1 4 2004

		1 - For State Registrar	State of I	Marylan		irtment of tificate of	Health and I Death		ene g. No. 2 (304	326	73
Physic	cian	Decedent's Name (First, Middle, Last) GLORIA PATRICI	A RODR	IGUEZ				2. Date of Death Month AUGUST		20 [°] 0°4	3. Time of Di	
/Med Exam		4a. Facility Name (If not institution, give s				4b. City, Town,	or Location of Death		<u>-</u>	ty of Death	3.10	
		NATIONAL INSTIT			LTH	BETHE		10.71.	MON	TGOME		
Funera Director		217 03 30017	M 2⊠F 7.	Age (In yrs. 2 9	Yrs.	If Under 1 Yea Months Day:		8. Date of Birth Month, Day 0 9 / 0 2 / 1	^{Year)} 7 4	9. Birthp Coun C C	lace (State or F try) Lumbi	a a
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City	Limits
Mary e-f sh	tor	Maryland Montgo	mery	Ga	aither	sburg					1√∑Yes 2	! □ No
vith the	Dire	10e. Street and Number		D		10f. Zip Code	77	10	-	f What Coun	try?	
eath v	Funeral Director	7728 Mineral S	PIIIB		S. 13. V	2 0 8	Hispanic Origin? (Si	pecify Yes or No-	Colu 14. Ra	III D 1 a	an Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show important: if item 27 is marked other than "natural", or items 25a or 28e-f show injury or other traumatic event, it a Maryland Examiner must be redified at another.	ē	Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?			Yes, specify Cu Yes 2□ N	ban, Mexican, Puert	o Rican, etc.)	tc.) Black, White.			е
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ould be filk Mental Hy arked oth	To B	Conrad DeJesus	Parra				Magda	alena Va	lenc	ia		
d 2 sho th and 7 is mu traum	10.3	19a. Informant's Name/Relationship (Ty) Freddy A. Rami				•	et <i>and Number or R</i> u eral Spri			•	-	a 1
Healt Healt tam 2		20a. Method of Disposition		20b. P		sition (Name of natory or other p				- City or To		6,
rmit. Pages partment of portant: If i y injury or or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	Md d	Natui	bal Ce	metery		aure	1, Mc	l	
permit. Departm Imports any inju		21. Signature of Fundal Service Conse	AM.		22 F	Name and Add	ress of Facility St	terling terling,	Fune Va	ral 5	Servic	е
Physiciar	1	23a. Part1 Enter the disease, or complishock, or hear failure. List only or Immediate Cause (Final disease or condition	cations that cause cause on each	h line.	n. Do not ente	er the mode of d	ying, such as cardiac	or respiratory arre	st,		Approximate Interval Betwe Onset and Dec	ath
/Medica Examine		Due to (or as a consequence of): Human Immune Deficiency Virus										
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
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cate be e	dlcal		1									
certifii nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	me of pregna	incy	_===			23d. D	ate of delive	ry	
v requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown								Month Day Year		
s that med by e deta	by Pr	Part II. Other significant conditions cor	ntributing to deat	h but not res	ulting in the ur	nderlying cause g	given in Part I.	23e. Did toba	acco use co	ntribute to th	e cause of dea	ith?
w requires that been signed b								1 🗆 Yes	¥∏No	3 Prob	ably 4 🗆 Unk	known
e lav has	ompleted							24a. Was an autopsy perform	1	. Were autor prior to cor death?	osy findings ava apletion of caus	allable se of
. ⊢ tad	င္ပ	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes 2	□No	1 ☐ Yes	21 No	
Physician: this certific	OB B	aumminar?	lospital: 🍋 Inp	atient 2	ER/Outpatien	t 3 DOA	thor	ome 5 Resider		ther (Specify)	
ding Phys h, After this (on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I		28b. Time of Injury	28c. lnj W		28d. Describe how	v injury occu	ırred		
ttandi death. stor: A	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e Place of	Injury - At ho	ome farm str	M 1 {	☐Yes 2☐No	28f. Location (Stre	et and Num	ober or Rura	l Route Numbe	er.
of or Attanding after death, Director: Afte d in by the fune	ertif	4 Homicide determined	building	, etc. (Specif	y)	331, 123(3) 9, 311(3)	,	City or Town,				.,
se Hospitel or Attanding P n 24 hours after death. se Funeral Director: After I	edical C	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exemit		s of examina			time, date and place opinion, death occu					
To the I within 2 To the I complet	Me	29b. Signature and title of certifier					nse number 058838		_	ed (Month, I		1
		- Edving on	ne						AUGU	OI 1/	, 2004	1
		30. Name and address of person who co	empleted cause of MD				r 120mura	CDA MAT) V T T T	D 200	0.00	
s	tate	31. Date filed (Month, Day, Year) OCT 1 4 2004		istrar's Signa		south!	E, BETHE	DIA, MAI	LILAN	u ZUč	72	
Regis	strar	UCI 1 4 2004	MATERIAL		14	104021						

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 2, 2004

111 Penn Street, Baltimore, Maryland 21201

			1 State	artment of Health and Mertificate of Death		0001	275 275 281 WIR (2.48	
			Registrer 1. Decedent's Name (First, Middle, Last)	Timcate of Death	2. Date of Deat	eg. No.	3. Time of Death	
	Physici	an	III. SOUR E-021 CET CORE FOR		Month	Day Year	м	
ŧ	/Medic	al	Alma Monique Reeder 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	septem	ember 29 04 9:45		
Į.	Examin	er	4a. Facility Name (II not institution, give substantament)					
			Clearview Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Hagerstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washington	ol County place (State or Foreign	
	Funeral Director		1 M 2 XF 67 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, November	Year) 1936 Pe	ennsylvania	
			190-28-4992 Usual Residence of Decedent			1 1 1 1 1 1	JIIISY I VAIIITA_	
	yo *		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
	Man	ğ	Maryland Washington Hagerst	own			1 ☐ Yes 2 No	
	r 28a	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	ntry?	
	3e o	0	145 Sunbrook Lane	21742		U.S.A.		
	deeti	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Ameri Black, White,		
36	s 1 and 2 should be filed within 72 hours effer deeth with the Maryland of Heelth and Mental Hyglene. Item 27 is marked other then "naturel", or Iteme 23e or 28a-f ehow other traumatic event, the Madical Examiner man be notified at	by Fur	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	nicali, etc./	Specify: White,		
Ş	hour	Pe	15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/In	ndustry	
<u> </u>	n 72 "na Indic	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of workii DO NOT use retired)	ng		,	
2	the.	Ē	Elementary/Secondary (0-12) College (1-4or 5+)	egistered Nurse		Physicans (Office	
0	Hygid Hygid Sther		17. Father's Name (First, Middle, Last)	18. Mother's Name			7.1.100	
an	d be ental ked o	To Be	C Theodore Shade	Alma I	O. Crain	10		
2	should and Men s marke umatic	-		ling Address (Street end Number or Rura			Code)	
Š	nd 2 sith e 27 is r treu		Jay C. Reeder (Son) 109	68 Dam No#5 Rd. Cle	ear Sori	ng Maryland	1 21722	
ē,	Hee tem		20a. Method of Disposition 20b. Place of Disposition			20c. Location - City or To		
2	y or			rg Crematory Oct.	1, 04	Smithsburg	Maryland	
Baltimore, Maryland 21215-0036	permit. Peges. Depertment of the Importent: If its eny injury or of once.	li	The state of the s			Fiery Fuer		
a	Depermination of the populatio		NI Dural C. V. Ib. S.	331 Eastern Blvd. N	_	-		
			23a Part1, Enter the disease, or complications that caused the death. Do not el				Approximate	
	Diametete.		shock, or heart failure. List only one cause on each line.	-011 00 a	Mi	FRACTALL	Interval Between Onset and Death	
1	Physician /Medical		disease or condition resulting in death) a	ER WITH BRA	1112	- 145 1781S		
	Examiner						unknown.	
		-	Sequentially list conditions, if any, leading to immediate cause. Either Underlying					
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
Ć,	exec n en lel-tr	Exa	resulting in death) Last Due to (or as a consequence of):					
8760,	requires that the deeth certificate be executed een signed by the ettending physicien end nould be deteched for use as the burlet-trensit	Cai	d					
φ	ifficat g ph) es th	च						
Box	thet the deeth certified by the ettending deteched for use es	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	_	23d. Date of deliv		
œ	deeti e ette	Cla	in the past 12 months? 4 Pregnant at time of death 5	Other (specify)		Month	Day Year ∧_	
P.O.	t the by th	h ya	9 □ Unknown	•			T	
	res the signed be det	Ž	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?	
Ĕ	w require been sig should b	B	Diabetes Mellitus	•	1)A(Ye	es 2 □No 3 □ Prot	bably 4 Unknown	
8		pet			24a. Was ar autops	n 24b. Were auto	opsy findings available ompletion of cause of	
æ	The lew ste hes b pege 2 s	Completed			perform	ned? death?	2□No NA.	
ta Ta		0	25. Was case referred to medical	26. Place of Death			1-71	
≥	Phyelclan: this certific rel director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other: 4 Nursing Hor	ne 5 Reside	ence 6 Other (Specia	fy)	
Ö	g Phy er this erel di		27. Manner of Denth 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at 2		ow injury occurred		
<u>ō</u>	Attending r death. sctor: After by the fune	atio	2 Accident investigation	A M 1 ☐ Yes 2 XÎNo		NIA.		
Division of Vital Records,	호흡등	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St. City or Town	n (Street and Number or Rural Route Number, Fown, State)		
	Hospital 24 hours e Funerel I tely filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	ath occurred at the time, date and place, a	and due to the ca	ause(s) and manner as s	stated.	
	A Ho	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, da	ate and place, and due t	o the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,		
			I Remain MD	0058181		09/30/20	104	
۱.	-30		30. Name and address of person who completed cause of death (Item 23a) (Type					
3	30		KODUAN PEPRANT, 382 SOU	TH CLEVERAN A	IF HA	GBES TOWN	MD 21740	
	316		30. Name and address of person who completed cause of death (Item 23a) (Type KODUAI+ PERAI+ 382 SOU) 31. Date filed (Month Per Year) 4 2004 32. Rigistrar's Signature 33. Date filed (Month Per Year) 4 2004	1. 40				
J.A.	Regist	ar	Jelle D. J.	pera				

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	aryland		irtment of H tificate of L			giene Reg. No		32676	
H			Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death	
	Physici: /Medic		BEN	REZNEK					SEPTEME	EPTEMBER 26, 2004 9:			
	Examin	er	4a. Fecility Name (If not institution, give st.				4b. City, Town, or				y of Death	DX	
			MONTGOMERY GENERAL 5. Social Security Number 6. Sex	HOSPITAL	e (In yrs. lasi	t hirthday)	OLNE	Y If Under 24 Hrs.	8. Date of Birt		TGOME	KY plece (State or Foreign	
	Funeral Director	1		M 2□F	90	Yrs.	Months Days	Hours Min.	AUG 10	1914	WASI	HINGTON, DC	
			Usuel Residence of Decedent										
	show		10a. State 10b. County		10c. City, T							10d. Inside City Limits 1 XYes 2 No	
	8a-f	Director	MARYLAND MONTGOMER	Y	511	LVEK	SPRING			10- Chi of	. Citizen of What Country?		
	with the		10e. Street and Number	TVE #2C			10f. Zip Code 20906			UNITE			
	n 72 hours after deeth with the Maryland *natural; or items 23e or 28e-f show gdical Exarchet much be nytified at	Funeral	3501 FOREST EDGE DR	2. Was Decedent I		13. \	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	- 14. Ra	ce - Ameri	can Indian,	
0	r iten	Fun	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ N If Yes, Give		1	f Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Bla	ack, White,	etc.	
3	hours after tural; or ite	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Specify:		Spec	my: W	HITE	
9500-6121	72 h	Completed	15. Decedent's Educi (Specify only highest grade			(Give	tent's Usual Occupa kind of work done of	luring most of wor	king .	16b. Kind of	ndustry		
2	E 0 E	ם	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retired ANICAL EN			U.S.	GOVER	NMENT	
N	Hygier Hygier Sthertl		17. Father's Name (First, Middle, Last)	<u> </u>		ILLOIL	ZIIVIOZIE EIV		ne (First, Middle,				
al	S 2 2 5	o Be	EPHRIAM REZNI	EK				SARAH	I	REIBS	TEIN		
<u></u>	es 1 and 2 should to of Health and Ment of Item 27 is marked r oth i traumatic	F	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town	n, State, Zi	p Code)	
Ĕ	Health a		LAUREL B. SHARF, I	AUGHTER		11354	BAROQUE	ROAD, SI	LVER SPI	RING, M	D 20	901	
ē.	St. 28		20a. Method of Disposition 1	moval from State	20b. Plac	e of Dispo	sition (Name of matory or other plac		Date	20c. Location			
Ē	Pages ment of land or oury or o	•	'4 □Donation 5 □ Other (Specify)	illoval floar state	KING	DAVI	D MEM. GD	N. 9/28	/2004	FALLS	CHURC	H, VA	
Baitimore, Maryland	permit. Pages of Pepartment of Himportant: if the any injury or ot once.		21. Signature of Fineral Service Licens	The	n	ED 10	WARD SAGE 91 ROCKVI	LLE PIKE	L DIRECT	TION, I ILLE, M	NC. D 20	0852	
ž.	\$1		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each lin	the death.	Do not ent	er the mode of dyin	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between	
	Physician	1	Immediate Cause (Final disease or condition	RESPIR								Onset and Death 4 DAYS	
	/Medical		resulting in death)	Due to (or as								5 DAYS	
	Examiner		Sequentially list conditions, b.	ASPIRA			IONIA				_	5 DAIS	
	bed list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	ice oi).							
	be executed sician and burial-transit	xan	that initiated events c. Due to (or as a consequence of):										
8760	ate be e hysiciar the buri	dical	L d										
9	tificate ig phys as the	ledic											
Box	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Me	23b. was decedent pregnant	Bc. If yes, outcome			Ectopic pregnancy		23d. Date of delivery				
	e dea he att	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at 9☐Unknown	th 5	Other (specify)	.,-		Month Day Year				
P.0	The law requires that the de ite has reen signed by the a bage 2 should be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions cont	tributing to death h	ut not reculti	na in the u	nderhing cause give	en in Part I	23a Did to	obacco use co	ntribute to	the cause of death?	
S	ires that signed to I be deta	b	DEMEN		ou not result	119 111 1110 0	noonying occoor give	or are a				bably 4 Unknown	
0	require reen si should b	etec	<u>Demen</u>	TIU					24a. Was	20 24h	Wara aut	opsy findings available	
360	The law	Completed							autop	osy rmed?	prior to or death?	ompletion of cause of	
a		e Co	25. Was case referred to medical					OS Blace of Do	1 ☐ Yes	2 🗗 No	1 🗆 Yes	2 ∐ No	
5	ysician: is certific director,	To Be	avaminar?	ospital: 1X Inpatie	ent 2∏EF	VOutpatier	nt 3 DOA Oth	Ar.	Iome 5 Resid		ther (Speci	ifv)	
Division of Vital Records,	Attending Physician: r death. sctor: After this certific by the funeral director,		27. Manner of Death	28a. Date of Inju (Month, Da		8b. Time o		y at	28d. Describe I				
0	nding lath. r: After	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(100101) 24	,,,,,,	,,		Yes 2 □ No					
<u>X</u>	l or Attendater deatl Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At hom tc. (Specify)	e, farm, str	reet, factory, office		28f. Location (S City or Tox		nber or Rui	al Route Number,	
	itel o irs aft rel Di								E .				
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical	29a. Certifier 1 X Certifying Phys (Check only 2 Medical Examin one)	ician: To the best er: On the basis o and manner st	of examinatio	edge, deat n and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the arred at the time,	cause(s) and r date and place	nanner as a, and due	stated. to the cause(s)	
	To the within 2 To the complet	Med	29b. Signa The and title of certifier	and manner so			29c. Licens	e number		29d. Date sign	ned (Month	Day, Year)	
)	F ≯F ŏ		DALTA				00д	35045		SEPTEM	BER 2	8, 2004	
	6		30. Name and address of person who	impleted cause of c	death (Item 2	3a) (Type,							
	w.		PHILIP G. HENJUM,	M.D., 34	16 OL	ANDWO	OD COURT,	#204 O	LNEY, MA	RYLAND	208	32	
		ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signatu		Souk						
	Regist	rar	CED 2.9 200	14 1264	we	1	July way						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Sherman 0855 October 5 2004 ennis ALLEN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cuty Hospital Bultimal Uty
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Hopkins Johns 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X) M 2□ F Yrs. 44 Director 20,1960 MARYLAND APRIL 214-80-9002 death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "naturel", or items 23e or 28a-f show MARYLAND PRINCE GEORGES 1 Yes 2 No UPPER MARLBORO Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 11570 DULEY STATION ROAD 20772 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
The Treat I flem 27 is marked other then "naturel; or flee any or other traumatic event, the Marinal Exercition ury or other traumatic event, the Marinal Exercition. 1 ☐ Yes X No If Yes, Give 1 Never Married 2XXXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 📉 o Specify: Specify. þ 3 Widowed 4 Divorced WHITE Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT MECHANIC HEAVY TECH. SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES ALLEN SHERMAN GLORIA MAE WERNER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER SHERMAN-WIFE 11570 DULEY STATION RD. ,UPPER MARLBORO,MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20772 20a Method of Disposition permit. Pages:
Department of h
Important: If Its
eny injury or ot 1

Burial 2 □ Cremation 3 □ Removal from State METHODIST CEMETERY 10-8-04 * 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND M00479 Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee LA PLATA, MARYLAND Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician poxia 24 hours /Medical Due to (or as a consequence of): **Examiner** 3 weeks synovial cell cancer metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for ☐Yes 2☐No Ö 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 2 No 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA J. this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical th e 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ES-000 Blum, medical doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Johns Hopkin (Hopital, Tower 110, Doctn's Lounge, 600 N. Wolfe, Baltimore 21287 MARISSA BLUM, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 1 4 2004 Registrar

DHMH 17 Rev 1/2001

			For	State of I	•	epartment of h		d Mental Hyg	giene	00/20
			Registrar 1. Decedent's Name (First, Middle	h Last)		Sertificate of	Deam	2. Date of Dea	Reg. No.	3. Time of Death
п	Physici	an	1. Decedent's Name (First, Middl		tege.	5.		Month	Day Yes	
	/Medic		WIIIam				ar Location of D	Octobe	4c. County of D	09
	Examin	er	4a. Facility Name (If not institution		, ,	4b. City, Town, o			Baltin	
			5. Social Security Number	of Mary 1	Age (In yrs. last birth	day) If Under 1 Year	timo			
	Funeral Director			10 M 2□F		Months Days		Ain (Month Day	Year)	Birthplace (State or Foreign Country)
			263-52-2762 Usual Residence of Decedent		01			4/23/	1937 F	lorida
	/land		10a. State 10b. County	,	10c. City, Town	or Location				10d. Inside City Limits
	Man Fied	to	MD. H	arford		Ja	rretts	ville		1 ☐ Yes 2 🛣 No
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	3a o	0	4043 Old F	ederal Hi	ll Road		2108	34	United	States
	ms 2	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin?	(Specify Yes or No-		merican Indian,
9	after or Ite	Ē	1 Never Married 2 Mar	Armed Force	No	1 ☐ Yes 2 No		reno Alcan, etc.)		hite, etc.
03	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examinat must be mailled at	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:	TLI Yes ZAINO	Specify:		Specify:	White
5-0036	n 72 hours after death with the Marylan "natural", or Items 23e or 28e-1 show idical Examinat the molified at	Completed	15. Deceder	nt's Education est grade completed)	16a. [ecedent's Usual Occup Give kind of work done	pation during most of	workina	16b. Kind of Busine	ss/Industry
2121	within ene. than *	npl	Elementary/Secondary (0-12)	College (1-4	or 5+)	ife. DO NOT use retire	(d)			
2	ed w ygier nar th	S	12	5+	Mat	hematics				Education
pu	be fil tal H d otf	Be	17. Father's Name (First, Middle,					Name (First, Middle,		
Maryland	ges 1 and 2 should be filed within to of Health and Mental Hygiene. If item 27 is marked othar than or other traumatic event, the Mean of the file Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event, the Mean traumatic event	P	Daniel	Downey		steger			Lenore	Newell
Jar	and and risin		19a. Informant's Name/Relations							a, Zip Code) 21084
	l and lealth m 27		Patricia A. 20a. Method of Disposition	Steger/w		3 Old Fe				ttsville,Md
3altimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		1 Burial 2 Cremation 4 Donation 5 Other (S	3. Removal from Sta	alo I	Disposition (Name of crematory or other pla		10 11	20c. Location - City	
ţ	permit. Pag Department Important: I any injury c				nd Highv	riew Mem.				. Maryland
Bal	permit. Departr Importa any inji		21. Signature of Funeral Solvice	Иселене 5	10	22. Name and Addre				Maryland
	40280		11, Succe	con / w	21			Son Fund		
			23a. Part1. Enter the disease, o shock, or heart failure. List	only one cause on eac	h line.					Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a/	Sophae	ae/	Verto	cation	7	
	/Medical Examiner		resulting in deality	Due to (or	as a consequence	4				2 Weeks
Н		_	Sequentially list conditions,	b. Due to for	caiasti	11115				2 0000
	ed isit	Jine	Sequentially list conditions, tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	as a nonsequent o or					
	xecul and II-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):				
8760,	ate be executed hysician and the burial-transit	alE			•					
687	phys phys s the	dical		d.						
	leath certifica attending pt I for use as tl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of	delivery
Box	death e atter	clar	in the past 12 months?		n 2 ☐ Fetal death It at time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		Month	Day Year
O.	the d y the	ıysi	9 ☐ Unknown	9□Unknow		(-,				
σ.	w requires that the death been signed by the atte should be detached for		Part II. Other significant conditi				ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds	puires n sign lld be	q p	Paroxysmal	Atrial	Fibill	ation		1 □ Y	es 2 1 No 3	Probably 4 Unknown
CO	taw rec as bee 2 shou	lete	History 60	c 5+10	ore_			24a. Was a	an 24b. Were	autopsy findings available
Re	hysician: The taw his certificate has b I director, page 2 s	Completed by						autopperfor	med?death	autopsy findings available to completion of cause of ?
a	in: T ificat or, pa	e C	25. Was case referred to medica				OR Place of I	1 ☐ Yes Death (Check only or		es 2 No
S	Physician: this certific al director,	To B	examiner?	Hospital:	patient 2 ER/Out	atient 3 DOA Ott	200	g Home 5 Resid		nacifu)
of	ding Phys th. After this funeral dii	<u> </u>	27. Manner of Death	28a. Date of I		ne of 28c. Inju	rv at		ow injury occurred	респу
on	nding th. : Afte	tloi	1 ☑Natural 5 ☐ Pendii 2 ☐ Accident invest	ng (Month, igation	Day Year) Inj	ury Wo M 1□	rk?]Yes 2 ☐ No			
Division of Vital Records,	Attaur dea	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of	Injury - At home, farr	n, street, factory, office		28f. Location (S	treet and Number or	Rural Route Number,
Ö	alor s afte Il Dire	Certification:	4 Homicide	building	, etc. (Specify)			City or Tow	n, State)	
	pspit hours unera y fille		29a. Certifier 1 Certifyii	ng Physician: To the be	est of my knowledge,	death occurred at the ti	me, date and pla	ace, and due to the o	ause(s) and manner	as stated.
	To the Hospital or Attanding PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	one)	Examiner: On the basi and manner	r stated.	or investigation, in my t	opinion, death o	ccurred at the time, o	ate and place, and d	ue to the cause(s)
	To t To 1	Σ	29b. Signature and title of certifie	or M		29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
			Danie	W 1/1/2	c, M	.D. W	1271	/	October	6 2009
	15		30. Name and address of person Daniel Wy	Inversity cof	of death (Item 23a) (Thurpland	ype, Print)	th Gue	n street	Bultimon	- Maylord 2/211
	Sta Registi		31. Date filed (Month, Day, Year OCT 1 4 200	32. Reg	jistrar's Signature	Spark				ine to the cause(s) onth, Day, Year) 6 2004 Mayland 2121

	··		1 - For State Registrar		Maryland / Depa	artment o			and M		Reg. No.		35570
	Physici	an	Decedent's Name (First, Middle,							2. Date of Do	aath Day	Year	3. Time of Death
	/Medic	cal	Fannie Jane Sk		ber)	4b. City, To	wn. or L	ocation o	f Death	4c. County of E			000
	⊏xanııı	ier	Washington Cour			Hage						shingt	
	Funeral				. Age (In yrs. last birthday)	If Under 1 \ Months D	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, Di May 5,			rthplace (State or Foreign ountry)
	Director		214-48-4709 Usual Residence of Decedent	ZX W	76 Yrs.					May 5 ,	1928		D
	show ad at		10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits
	e Mar	ctor	MD Washi	ngton	Hancoc	k							1 XYes 2 □ No
	vith th	Dire	10e. Street and Number			10f. Zip Co					10g. Citize	n of What C	ountry?
	eath v	era a	214 Myers Stree		lent Ever in U.S. 13.		175C		rin? /Sne	oify Vac or N	USA 14		erican Indian,
ري وي	riter d	Funeral Director	1 ☐ Never Married 2 ☐ Marrie				, Puerto I	cify Yes or No Rican, etc.)	17	Black, White, etc.			
903	72 hours after dea "natural", or items often Examiner ru	d by	3 XWidowed 4 □ Divorced	ed 1 Tes 2 If Yes, Give Year or Da		1 ☐ Yes 2 ☐	XNo	Specify:			Sį	pecify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28a-f show Ita Madical Examiner roust be multinal at	Completed by	, 15. Decedent' (Specify only highest		(Give	dent's Usual C kind of work of DO NOT use i	done du	ion <i>ring m</i> ost	of working	ng	16b. Kind	of Business	/Industry
212	t withii iene. r then	ошр	Elementary/Secondary (0-12)	College (1-	4or 5+)	omemake					Own	Home	
pu	should be filed within 72 hours after death with the Maryla of Mental Hygiene. marked other than "natural", or Items 23e or 28a-f show marked other than "natural", and item was the rutilitied at matic event, the Modical Experiment must be rutilitied at	Be C	17. Father's Name (First, Middle, L	ast)	-		1	8. Mothe	r's Name	(First, Middle	, Maiden Su	ımame)	
Maryland	should be and Mental s marked o	To I	Franklin Price							ly Nor			
Mar	nd 2 shouth and 27 is my		19a. Informant's Name/Relationsh			*				/ Route Numb		own, State,	Zip Code)
	1 an Hea Hea Hem		Lloyd I.Divelbli 20a. Method of Disposition	.ss/compan	20b. Place of Dispo cemetery, crei					ck, MD		tion - City or	Town, State
Baltimore,	000		1 N Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Price-Wes				0/01	/04	Little	e Orle	ans,MD
alti	permit. Pag Department Importent: h any injury o		21. Signature of Funeral Service L	icensee		2. Name and A							in Street
_	80 E E 9		Kuch	> CAN								ck,MD	21750-0368
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that ca only one cause on ea	used the death. Do not ent	0							Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Mc	LastATIC	154	(e e	IST	(cane	er		
B	Examiner		Due to (or as a consequence of):										
	n =	ner	Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequence of):	1 -							
	te be executed ysician and te burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	-A)								
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				r as a consequence of):								
Ø	ificate g phys as the	edicai		d									
Вох	eath certific attending p I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant				230	d. Date of de	•				
	at the dea by the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of death 5	Ectopic pregr Other (speci						Month	Day Year
P.0	res that thisigned by		Part II. Other significant condition	ns contributing to dea	ath but not resulting in the u	nderlying caus	se given	in Part I.		23e. Did	obacco use	contribute to	o the cause of death?
Vital Records,	w requires been sign should be	ed by								10	Yes 2 📈	√0 3□P	robably 4 Unknown
900	e law re has bee je 2 sho	Completed								24a. Was			utopsy findings available completion of cause of
Ä		Com									ormed? 2 No	death?	·
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	1-01-01-				of Death	(Check only	one)		
of	Phys this ral dii	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	patient 2 ER/Outpatier		Other:	4 🗀 Nui		ne 5 Resi			ocify)
ion	nding h th. r: After e funer	ation	1 Natural 5 Pending 2 Accident investig	(Month	, Day Year) Injury	м	Injury a Work?	s 2 🗆 N					
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could no 4 Homicide determine	286. Place C	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, of	ffice		2	281. Location (lumber or R	ural Route Number,
	oitel o urs aft rel Di												
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai	29a. Certifier 1. Certifying (Check only one)	Physician: To the bas xaminer: On the bas and manne	pest of my knowledge, deatl sis of examination and/or in er stated.	occurred at t vestigation, in	the time, my opir	, date and nion, deat	d place, a h occurre	ind due to the ed at the time,	cause(s) an date and pla	d manner as ace, and due	s stated. e to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	. Λ			icense r		2 0	/			h, Day, Year)
•	. i		> tand "	when			00	603	7 - 1	6	09 1	13/0	7
	4		30. Name and address of person w	mo completed cause	of death (Item 23a) (Type,		6	1)0a	10	ourt	1+10	Ma	1.21742
	Sta	-	31. Date filed (Month, Day, Year)	i i	gistrar's Signature					ourt_	1 1		
	Registr	ar	OCT 1 4 2	004 Se	winder of	Som	1						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** SEPTEMBER 26, 2004 ROSE FREDA SALTZ 11:45 a^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5225 Pooks Hill Road, #223 South Bethesda Montgomery 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔼 F Yrs. Director 566-46-2595 92 10, 1911 | PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show event, the Medical Examiner must be notified at Director 1 Yes 2 □ No MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5225 POOKS HILL ROAD or Items 23e #223 SOUTH death Completed by Funeral UNITED STATES OF AMERICA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 2/1s marked other than "natural" or linemay injury or other frame. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Specify: WHITE 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS ROSE 2 ROSEE WACHS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA S. ZELENKO - DAUGHTER 7516 VALE ST. CHEVY CHASE, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remover from State 4 ☐ Donation 5 ☐ Other (Specify) MT. SINAI MEM. PARK 10/01/04 LOS ANGELES, CA 21. Signatury of Funeral Survice Lie Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD James 23a. Part1. Enter the diser of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I st only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4 MONTHS NON HODGKINS LYMPHOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Irjus) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform<u>e</u>d 2X No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🔯 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) D22775 September 28, 2004 eac zude 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick G. Barr, M.D., 5454 Wisconsin Avenue, #1300 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 29 SEP 2304 Registrar

				State of	Maryland		tificate of	Death	-	Reg. No.	04	32681
	Physicia	1. Decedent's Name (First, Middle, Las	st)					2. Dete of De Month	Day	Year	3. Time of Death
200	/Medica	FRANCES SH			t1			4b. City, Town, or L		BER 23,		8:00 PM
s.d	Examine	4a Fecility Name (If n HEBREW HOM	IE OF GR	EATER WA	ASHINGT(ON			VILLE	4c. County		GOMERY
	Funeral	5. Social Security Num			7. Age (In yrs. k		If Under 1 Year Months Deys		8. Date of Birt (Month, Oe	h v. Year)	9. Birthpl Coun	lece (State or Foreign
-	Director	578-48-648	32	□M 2対F	93	Yrs.			NOV 10,	1910		YORK, NY
	tand	Usuel Residence of Di 10a. State 1	Ob. County		10c. City	, Town or Lo	cation				10	0d. Inside City Limits
	ath with the Marylan s 23a or 28a-f show nust be notified at	MARYLAND	MONTGOM	ERY				ROCKVILLE				1X Yes 2□ No
	vith the Ma or 28a-f s	10e. Street end Numb		BICI			10f. Zip Code	ROOKTIBBE		10g. Citizen of	Whet Coun	try?
	23e	6121 MONTE	ROSE ROA	D				20852				.S.A.
	fter daath v r items 23 riner must	11. Marital Status		Armed For		5. 13. V	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp oan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Blad	ce - America ck, White, e	
20	within 72 hours after daath with the Maryland ene. than "natural", or items 23a or 28a-f show he Madical Examiner must be notified at	1 ☐ Never Married 3 ☑ Widowed 4		1 ☐ Yes If Yes, Give Year or Da	2 X INo tes:	,	I□Yes 2X∏ No	Specify:		Specify	v: W:	HITE
9	2 hou	15	5. Decedent's Ed	ucetion		16a. Deced	lent's Usual Occu	pation		16b. Kind of B	usiness/Ind	dustry
218	ed within 72 ho ygiene. er than "natura t, the Medical I	(Specify Elementary/Second	only highest gre ary (0-12)	de completed) College (1-	4or 5+)	life. L	King of work done DO NOT use retire	during most of work	ing			
7		12					SECRET					VENMENT
and	be fill d off	17. Fether's Neme (Fi						18. Mother's Nam		Maiden Surnan	10)	
Z	should ind Man marke umaric	SOLOMON LE		Type Print)		19h Mailin	n Address (Stree	t and Number or Rur	MILLLER	er City or Town	State Zin	Code)
Ma	lith an 27 fa r	RONALD RUE					-					LAND 20877
Ē,	tem item	20a. Method of Dispos				ace of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or To	wn, State
m	Pages Int. If Ite	ty⊡ Burial 2 □ 0 4 □ Donation 5			tate		ANON CEM		/24/200	4 ADEI	LPHI,	MARYLAND
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed Department of Health and Mantel Hyg Important: if Item 27 Is marked other any Injury or other traumatic event, once.	21. Signature of Fane	ral Service Licen	see			Name and Addr	ess of Fecility	MEMOTE A	CHADE	e Ti	ATC.
ш	20.5 2	THAT!	M			11	70 ROCKV	ILLE PIKE	, ROCKV	ILLE, MA		
		23a Part . Enter the shock, or heart	diseas , or comp	olications that ca one cause on ea	used the death ch line.	. Do not ente	er the mode of dy	ing, such as cardiac	or respiratory a	rest,	1	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Ceuse (Fir	nal		- 1	- 0 1	A	-11 2	000		1	Onset and Death
	Examiner	disease or condition resulting in death)	1001	a				HRON	17051	5		
					Due to (or	as a conseq	uerice or).				!	
	ficate be executed j physician end ss tha bunel-transit	Sequentially list cond	itions,	b	Due to (or	as a conseq	uence of):					
60,	cian e	Sequentially list cond if eny, leading to immo cause. Enter Underly Cause (Disease or injustat initieted events	ediate ing ury	C								
68760,	ficate be physicia se tha bur	that initieted events resulting in death) Las	st		Due to (or	as a consequ	uence of):					
Box (d								
Ď.	death e atte	Part II. Other significe	ent conditions co	ontributing to dea	ath but not resul	Iting in the ur	nderlying cause gi	ven in Part I.	23b. Dld 1	obecco use co	ntribute to	the cause of death?
<u>О</u> .	The law requiras thet tha death cert ate has been signed by the attending page 2 should be detached for use		11	_		,	, ,		1 🗆 '	Yes 2 No	3 🗆 Prob	ably 4 Unknown
Š,	gne igne bed		144PE						r	/\		
0	requir	VA	SCUL	AR	DE	ME	NTIA			an autopsy rmed?	ava	ore autopsy findings allable prior to appletion of cause
3ec	e lav								7546.975	V		déath?
la:	ician: The k certificate ha rector, paga	25. Was case referred	t to modical					OC Plans of Pass	- (Charles-to-	66 30 No	1 🗆	Yes 2□ No
5	Physician: rthis certific rral director,	examiner?	1	Hospital: 1 □ In	patient 2□E	R/Outpatien	t 3 DOA Ot	26. Place of Deat her: 4 Nursing Ho		ne) lence 6 □Oth	er (Specify)
<u>6</u>	g Phy ler thi	27. Manner of Death	5 ☐ Pending	28a. Date of		28b. Time of Injury	28c. Inju			ow injury occur		
Sio	Attanding or death. actor: After by the fune	2 ☐ Accident	investigation					Yes 2□No				
-	tal or Attanding Piss after death. al Diractor: After the in by the funers	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place	of Injury - At hor g, etc. (Specify)	ne, farm, stre)	et, factory, office		28f. Location (S City or Tox	Street and Numb m, State)	er or Rural	Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifica completaly filled in by the funeral director.	29a. Certifier	Certifying Phy	vsician: To the h	est of my know	rledge, death	occurred at the ti	ime, date and place,	and due to the	cause(s) and ma	inner as st	ated.
	he Hospit in 24 hour he Funeri pletaly fill				sis of examinati			opinion, death occur				
	within To the comp	29b. Signature and titl	e of certifier	, ()			29c. Licen			29d. Date signe		
	(\mathfrak{D})	N	1100	el m	1)-		1)/8	084		SEPT.	24,	2004
	3	30. Name end address	s of person who	completed cause	of death (Item	23e) (Type, I		0		SEPT. E,MD	7 - 7	>
		31. Date filed (Month,	Day Year	4 M	gistrar's Signati	1 AVC	NTROSE	E RD Ke	CKVILL	E MI)	200	56
5	State Registra	SE		004	Benever	19	Spark	2		,		

DHMH 16 Rev 6/95

FRANCES SHANDALOW

			For State Registrar	State of I	Marylan		artment of H		and Mental Hy	giene	04 32682
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month	aath Day	3. Time of Death
	/Medic	al	Joyce Darlene SHC		nel .		4b. City, Town, or	1 contion o	Octobe		2004 745 PM y of Death
	Examin	er	Washington County				40. City, 10Wil, 01	20021	T) () O		ashinaton
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Date of Bir Min. (Month, Da	rth	Birthplace (State or Foreign Country)
	Director		220-42-7398	□M 2⊠F	61	Yrs.	lilonais bays	110013	Aug. 26		Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ecation				10d. Inside City Limits
	Many e-f sh	tor	Maryland Washin	gton			Hagers	town			1⊠Yes 2□No
	or 28	Dire	10e. Street and Number				10f. Zip Code				What Country?
	s 23a	erai	136 Broadway	12. Was Decede	nt Ever in II	6 13		21740	zin? /Spocifu Von or No	USA	ce - American Indian,
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other then "naturel", or items 23s or 28e-f show or other treumetic event, It e Marked Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Force 1 Yes 21 If Yes, Give Year or Date	s? ☑ No	ŀ	f Yes, specify Cuba		gin? (Specify Yes or No , Puerto Rican, etc.)	l l	nck, White, etc. white
21215-0036	72 hou	Completed by	15. Decedent's Ec (Specify only highest gra			16a. Dece	dent's Usual Occupa	ation	of working	16b. Kind of E	Business/Industry
2	ne.	mple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT use retired)	o. nog		••
d 2	e filed within al Hygiene. I other then ' vent, It e wa		12 17. Father's Name (First, Middle, Last)	0			cler		r's Name (First, Middle	reta Maiden Sumai	
an	Mental Mental arked o	To Be	Joseph William G						Evyline Lor		
Maryland	2 shoul and M is marl eumeti		19a. Informant's Name/Relationship (19b. Mailie	ng Address (Street a	and Numbe	r or Rural Route Numb	er, City or Town	, State, Zip Code)
Z,	os 1 and 2 of Health item 27 i		Kenneth Shoemaker	- son	20h B	100	Kuhn Av	enue,	Hagerstown	<u>_</u>	
altimore,	Pages 1 nent of P ent: If ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		te c	emetery, crei	natory or other plac	1			- City or Town, State
ij	그 돈 뿐 글		* 4 □ Donation 5 □ Other (Specify 21. Signal uneral Service Licer	·	KO:		Cemeter No me and Addres		10/5/04 MINNICH		town, Maryland
ñ	Dermi Depa Impo any It		SCOTT!	M//	m	Care .	15 E.Wil	son B	lvd., Hage		
The second	Pnysician /Medical Examiner	Iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a	as a consequal as a consequal	ereb Hypi	er the mode of dyn FRI NE ERTEN	mo	shage	rrest,	Approximate Interval Between Onset and Death Dea
68760,	death certificate be executed e attending physician and of for use as the burial-transit	ledical Examine	resulting in death) Last	c Due to (or	as a conseq	uence of):					
P.O. Box		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3[Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of Chronic obstructions	ontributing to deat	n but not resi	ulting in the u	nderlying cause give	en in Part I.		obacco use con Yes 2 🗆 No	tribute to the cause of death?
Division of Vital Records,	The ate h page	Completed							24a. Was auto perfo 1 🗆 Yes	psy prmęd?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Zit.	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2 🗆	ER/Outpatier	Othe		of Death (Check only of rsing Home 5 ☐ Resi		and (Constitution)
ion of	Attending Phyer death. •ctor: After this by the funeral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		28b. Time of Injury	28c. Injury Work	at	28d. Describe	how injury occur	
Divis	i te	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	ber or Rural Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled it	edical	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basis and manner	s of examina	wledge, death tion and/or in	vestigation, in my of	oinion, deat	d place, and due to the h occurred at the time,	date and place,	and due to the cause(s)
•	with com	Σ	29b. Signature and title of carifier	ms			D 5	128	12	29d. Date signe	od Month, Day, Year)
5	2H		30. Name and address of person who				1		St. Hog	.md	21740
	Sta Registr		31. Date filed (Mont OCT YOU') 4 2	2004 32. 79	strar's Signa	East ture	ned		7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 26, 2004 **Physician** LILLIAN SONIA SILVERSTONE 2:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11613 FULHAM STREET SILVER SPRING MONTGOMERY tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year APR 15, 1 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ F WASHINGTON, DC 76 วี928 577-36-3133 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Modical Examinar must be notified at 1√ Yes 2 No Funeral Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 20902 11613 FULHAM STREET UNITED STATES Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If Item, 27 is marked other than "natural", or Items 23sury or other straumatic event, the Model Examiline triunt. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SCHER CARLYN ٥ LESSNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELWOOD H. SILVERSTONE, HUSBAND 11613 FULHAM STREET, SILVER SPRING, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If ony injury or 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS. 9/29/2004 OLNEY, MARYLAND 21. Signature of Juneral Privice Liounsee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Jakey 1170 ROCKVILLE PIKE, ROCKIVLLE, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC LUNG DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown care nas been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTATIC LUNG CANCER TO BRAIN 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform rmed? 2X No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the 2 Accident within 24 hours after deatl To the Funeral Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 0 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Manie Mo whe co SEPTEMBER 28, 2004 D0593F 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

SEP 29 2004

ROBERT KRAMER, M.D.,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

& Sparks

SILVER SPRING, MD

2101 MEDICAL PARK DR., #210

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vaar **Physician** Raymond A. Smego, Sr. September 24, 3:34 P M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6421 Rock Forest Drive Apt. 104 Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** 1**X** M 2□ F 327-12-8352 Director 82 01/01/1922 Illinois Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28e-1 show if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28e-1 shov other traumatic event, the Medical Examiner must by restitive at 1 X Yes 2 □ No Director MD Montgomery Bethesda the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6421 Rock Forest Drive Apt. 104 20817 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: WWII þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired/Transportation& 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Chemical Purchasing Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John George Smego Anna Elizabeth Dubas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6421 Rock Forest Dr., Apt. 104, Bethesda, MD 20817 Lois V. Smego, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury oc 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 10/01/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) boronary Priysician uedrs dr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a considuence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1sease autopsy performs 2 NO 1□ Yes 20 No 1 Yes Hospital or Attending Physicien: Be 25. Was case referred to medical exagniner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1XYes 2 No Certification: To this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation after death.

Director: Aff 1 Yes 2 No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Thomicide within 24 hours after To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainted as stated. 29d. Date signed (Month, Day, Year) September 24, 2004 29c. License number 29b. Signature and title of certifier 1/e Pike, B-100, Rockville, MD 20852 Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVII 10m51 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

		State of Maryland / Department of Health 1- State Registrer Certificate of Deat	h	ene g. N. 1111 32685
	ician	***** Y DIIIZUOCUI DUIII VUII	2. Date of Death Month Se pt	
Exar	dical	er 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 234 Mealey Parkway Hagerstown	n of Death	4c. County of Death Washington County
Funer Direct		216-07-9357 Usual Residence of Decedent 1 M 2 F 89 Yrs. Months Days Hours	Min. (Month, Day, March 22	Year) 9. Birthplace (State or Foreign 1915 Maryland
Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Location Maryland Washington Hagerstown		10d. Inside City Limits 14 Yes 2 ☐ No
h with the 23a or 28 st be no	al Dire	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country? U.S.A.
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. dothar than "natural", or Items 23a or 28a-f show event, the Modic: Examiner must be notified at	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forcas? 1 Yes, Sive Year or Dates:		14. Race - American Indian, Black, White, etc. Specify: White
21215-0 sd within 72 ho giene. ar than "natur , the Modien!	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Secretary	ost of working	6b. Kind of Business/Industry
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Mer Mer arke	2	Patrick J. O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nurr	ara MacMillan	City or Town State Zin Code)
Ma nd 2 : ulth ar 27 Is r trau		Elizabeth Sullivan (Daughter) 232 Mealey Parkwa		and the same of th
Ord Pes 1		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		oc. Location - City or Town, State Hagerstown Maryland
Baltim permit. Pag Deportment Important:	once.			Fiery Funeral Home
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S, the set that gened be de	þ	Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Par	t I. 23e. Did toba	cco use contribute to the cause of death?
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99	o Be	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 DOA	ce of Death Check on one Nursing Home 5 Pesiden	ce 6 ⊟Other (Specify)
On Of ding Phy h. After this funeral d	on: T		28d. Describe how	
JIVISION OF Attancater deatler Diractor: in by the	Certification:	2 Accident investigation M 1 Yes 2 (3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		et and Number or Rural Route Number, State)
tha Hospital in 24 hours in the Funaral	edical	29a. Certifier (Check only one) 29a Certifier On the best of my knowledge, death occurred at the time, date and manner stated.	and place, and due to the cau eath occurred at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)
To tha within 2. To the I complet	Σ	29b. Signature and title of certifier DZ38		1. Date signed (Month, Day, Year)
3H-A			et Hacer	-stown unD 21782
Regi	State strar	te 31. Date filed (Month Day Year) 32. Resistrar's Signature		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** SWALES September 25 2001 0525 LEO /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) Pennsylvania 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** Days Min. 194-14-9782 81 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other traumatic event, the Medical Exercitival Last be troitled at 2008. 1 Yes 2 □ No Director Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 View Street 21742 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1√ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 X No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler Aircraft Mfa. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland William Grant Swales Lulu Vaughn McDivit 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Darlene M. Swales 815 View Street, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial Park 10-01-04 Hagerstown, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 R. hall B 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician NYCOXIA ·WS /Medical Due (or as a consequence of): Examiner preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner physician and The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by should be (DIO-624) Vasin 1 ☐ Yes ► No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an wilmag value caldismy 90,000 1 1 ves 6 No certificate Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 🚅 No Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. E. Kutzera Northern 747 Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 4 2004 Registrar

			1- State of Maryland / Departm	cate of Death	tal Hygien	enni	32687
	Physici		FLORENCE, PHRILE INCOM	N	ate of Death Month Da LPT. 19	ay Υθας 2004	3. Time of Death 1:00am.
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death		County of Death	I. OValii
			204 CHESAPEAKE VILLA	ROCK HALL		KENT	
	Funeral Director			nths Days Hours Min. (A	ate of Birth Month, Day, Year RCH 2,	9 Birthp Coun 1922 MAR	lace (State or Foreign try) YLAND
	yland		10a. State 10b. County 10c. City, Town or Location	1		1	Od. Inside City Limits
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36	or Ita	y Fui	Armed Forces? If Yes 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Mo If Yes, Give 1 □ Y	, specify Cuban, Mexican, Puerto Hicar	1, etc.)	Black, White,	
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Baltimore,	Pagas 1 and of Harmint: If item		20a. Method of Disposition 1 WBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	y or other place)		ocation · City or To	
Balti	permit. Pagas Department of Important: If i any injury or once.		FELL FELL	ne and Address of Facility OWS, HELFENBEIN & N SPEER ROAD, CHESTI	NEWNAM F	UNERAL HO	ME, P.A.
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al Re(total has	Completed		7	autopsy performed?	prior to con death?	osy findings available npletion of cause of
Vital	Physicien; Th this certificata ral director, pag	To Be	examiner?	26. Place of Death (Che Other: 4 Nursing Home		6 ☐ Other (Specify	
of	ding Phys			And the second s	Describe how inju)
ior	Attending ir death. actor: After by the fune	atio	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation N				
Division	al or Attendests after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f. building, etc. (Specify)		ocation (Street ar City or Town, State	nd Number or Rural 9)	Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C		urred at the time, date and place, and di ation, in my opinion, death occurred at	ue to the cause(s the time, date an	and manner as sta d place, and due to	ated. the cause(s)
8	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number		ite signed (Month, L	Day, Year)
)			Jun Kolos m.	D17036- Ma	., .	1121104	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D17036- Ma	Mid	216.20	
	Sta	ite	31. Date filed (Month, Day, Year) SFP 22 20114 32. Registrar's Signature	" - Ushiton	- 1.180	1420	
	Registr		SEP 2 2 2004				

			For State Registrar	State of Ma	aryland / Depa	artment of F		nd Mental Hy	giene Reg. No.	ni, poda	0.0
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	LICK	TOBB	EN,	TR.	2. Date of De Month	Day Day	Year 3. Time of De	eath A M
di An	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	TMC	DRE	BA	ty of Death LTMORE	
77	Funeral Director		034-24-3287	м 2 ⊠ F 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. 8. Date of Bit (Month, Date of May 22	th ay, Year) 1933	9. Birthplace (State or F Country) Mass.	-oreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Harford		10c. City, Town or Lo Aberdeen					10d. Inside City (
	h with the 3e or 28a st ke riviti	Funeral Director	10e. Street and Number 340 South Drive			10f. Zip Code 2100	1			What Country?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumatic event, the Madical Everth at treat ite inclified at once.	by	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	2. Was Decedent 8 Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origi an, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)		ace - American Indian, ack, White, etc. ify: White	
21215-0036	ed within 72 hogiene. er then "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most (d)	of working		Business/Industry Sovernment	
Maryland	should be file ind Mental Hy s marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) Frederick S. Tob			ı	Debb	s Name (First, Middle pie A. Cong	ger		
	and 2 shi lealth and m 27 Is m		19a. Informant's Name/Relationship (Type Evelyn E. Hillhous		er) 348 I	aburnum		or Rural Route Numb Agewood, M	aryland	21040	
Baltimore,	t. Pages 1 rtment of H rtent: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)		R. A. Fer	matory or other place cris & Co	. 10	/9/04	West Ch	ester, PA	
Bal	permit. Departr Importe any inju	21. Signature of Funeral Service Licensee Tarring—Cargo Funeral Home, P. Aberdeen, Maryland 21001—3399 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								Approximate	
	Priysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lin	AJACA	oere v	wal	Aduc	6cm	Interval Betwee	en ath
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cusuality in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):	usion					
68760,	icate be executed physician and s the burial-transit	edicai E	€ d								
P.O. Box 6	ath certif ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	/			ate of delivery Ionth Day Yea	ar
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the u	nderlying cause giv	en in Part I.		obacco use con Yes 2 2 00	ntribute to the cause of deal	
Il Records,	The law re cate has been page 2 sho	Completed	,					24a. Was auto perfo 1 Yes	an 24b. osy ormed? 2 2 No	. Were autopsy findings ava prior to completion of caus death? 1 ☐ Yes 2 ☐ No	ailable se of
f Vital	ding Physiclen: The lav h. After this certificate has funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No H	ospital:	nt 2 ER/Outpatier	nt 3□ DOA Oth		of Death <i>(Check only o</i>		her (Specify)	
sion of	Attending Pt r death. sctor: After th by the funeral		27. Manner of Death 1 Solutional 5 Pending investigation	28a. Date of Injur (Month, Day	y Year) 28b. Time o Injury	Wor	yat k? Yes 2 □ N		how injury occu	rred	
Division		Certification:	3 Suicide 6 Could not be determined	building, etc				City or To	wn, State)	ber or Rural Route Number	Γ,
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Phys Certify	ician: To the best of er: On the basis of and manner sta	of my knowledge, deat examination and/or in ited.	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	nanner as stated. , and due to the cause(s)	
)	To t To t	₩.	29b. Signature and title of certifier	Neurolos	sy reside	at AM-	e number	53	29d. Date signe	ed (Month, Day, Year)	
			30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,	Print) - (20)					
	Sta Registi		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registra	ar's Signature	Loud	,				

			For State Registrar	State of	Marylan		artment <i>rtificate</i>			and M	-	giene Reg. No.	nni.	207	0.0
			Decedent's Name (First, Middle, L.	ist)							2. Date of De	ath	Ulita		of Death
	Physici /Medio		Grace Cleary T	albot							Month Septemb	Day	Yeer 5, 2004		ам
	Examir		4a. Facility Name (If not institution, gi		nber)		4b. City, T	own, or I	ocation o		ocp com.		County of Dea		
			Manor Care- Pot	omac			Po	otoma	ac			l N	lontgon	lerv	
	Funeral		,		7. Age (In yrs.	•	If Under 1		If Under:	24 Hrs. Min.	8. Date of Bit (Month, Da	th	9. Bi	rthplace (State	or Foreign
L	Director		218-38-7784	1□ M 2 X F	9	7 Yrs.	Months	Dayo			Nov. 10		-	nectic	ut
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits
	Aaryi sho	ŏ													s 2 ☑ No
	28a-	rect	Maryland Montgo	mery	De	rwood	10f. Zip (Code				10a Citiz	en of What C	ountry?	
	an or	ū	16400 Equestria	n Lane				0855				rog. o.u.c		outling.	
	death me 2:	era	11. Marital Status	12. Was Dece			Was Decede	ent of His	panic Orig	gin? (Spe	cify Yes or No)- 1	USA 4. Race - Am	erican Indian.	
9	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed For	2 💆 No		If Yes, specif	fy Cuban	, Mexican	, Puerto l	Rican, etc.)		Black, Whi		
8	rel'.	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Da	etes:		1 ☐ Yes 2	Ľ No	Specify:			5	Specify: Wh	rce	
5	72 h 'netu	etec	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usual kind of work	done du	ion Irina most	of working	na	16b. Kin	d of Business	/Industry	
2	ithin ne. hen.	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. i	DO NOT use	e retired)							
2	lled w tygien her ti	S	17. Father's Name (First, Middle, Las			Tea	cher		10.11.15.		/F:		ducation	on	
anc	build be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "neturel" or Iteme 23a or 28a-1 show atte event, i're Medical Erial in terminative ricilities at	Be	Robert Cleary								(First, Middle, O' Louc		iumame)		
Maryland 21215-0036	hould d Me mark matic	Į.	19a. Informant's Name/Relationship	(Tima Print)		10h Mailie	. Addana /	(Carpot or					T 01-1-	7 0 11	
<u>S</u>	d2s than than 7 is i		· ·			1					/ Route Numb				
a)	1 an Heal tem 2		Grace T. Bryn/Da 20a. Method of Disposition	ugnter	20b. F	lace of Dispo	sition (Name	e of			Derwo		4D 2085 ation - City or		
<u></u>	ages int of tr. F. i		1 ☐ Burial 2 🛣 Cremation 3 [14 ☐ Donation 5 ☐ Other (Spec.		State	metery, crer Metrop	olita	ner place, N	1 5	-	ber 28,				
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or iteme 23s or 28s-f show eny injury or other treumatic event, the Predict Even in set must be redifficial an once.	- 19	21. Signature of Funeral Service Lice			Crema		Address	of Facility		04			, Virg	
ä	Ped ped my eny		Marine &	Inde	٠.	F:	rancis 00 Uni	J. vers	Coll	ins BI vd	Funeral	L Hom	e Inc. Sprin	a. MD	20901
			23a. Part1. Inter the disease, or con shock, or heart failure. List only	plications that ca	used the deat									Approxim	ate
	Physician		Immediate Cause (Final disease or condition											Onset and	d Death
1	/Medical		resulting in death)	a. <u>Sepsi</u> Due to (d	Sor as a conseq	uence of):		<u> </u>						3 Wee	ks
	Examiner		Sequentially list conditions,	b											
	₽ ≓	ner	f any, leading to immediate cause. Enter Underlying that initiated events		or as a conseq	uence of):									
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C											
60,	be ex cian a	Ē	Toodking in dodain, cast	Due to (d	or as a conseq	uence or):									
09/89	death certificate be executed e attending physician and of for use as the burial-transit	dicai		_ d											
× 6	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outo	ome of pregna	incv						22	ld Data of da	lincome	
ROX	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live bi	rth 2 ☐ Feta int at time of d	Ideath 3	Ectopic pred					23	ld. Date of de Month	Day	Year
o.	at the de by the a tached	nysi	1 Yes 2 No 9 Unknown	9□ Unkno	wn			,,							
	The law requires that the site has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the ur	nderlying cau	use given	in Part I.		23e. Did t	obacco use	ontribute to	the cause of	death?
Records,	quire en sig uld b	pa p	Hypertension, Di	abetes M	ellitus	3					10	/es 2 √	No 3 ☐ Pr	robably 4]Unknown
ပ္တ	aw re s bee 2 sho	piet									24a. Was		24b. Were at	utopsy findings	s available
	The lav	Completed										rmed?	death?	completion of 2 □ No	cause of
Vital	eicien: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
	Physic this ce al dire	2	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatien	t 3□ DOA	Other	4 🖾 Nur	sing Hom	ne 5 🗆 Resid	dence 6 (□Other (Spe	cify)	
ב	ding P. th. After t	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date or (Month	f Injury o, Day Year)	28b. Time of Injury		c. Injury a Work?			8d. Describe h	now injury	occurred		
<u>s</u>	Vttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not to	10	of latings . At his		М		s 2 🗆 N						
Division of	of or Attend after death Director:	Certification;	4 ☐ Homicide determined	288. Place	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, stre	et, factory,	office		2	8f. Location (S City or Tov		Number or Au	urai Route Nui	nber,
_	spite ours berel fille		29a. Certifier 1 X Certifying P	nysicien: To the	best of my kno	wledge, death	occurred at	the time	date and	1 place, a	nd due to the	raliso(s) ai	nd manner as	stated	
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 ☐ Medicel Exa one)	miner: On the ba	sis of examina	tion and/or inv	estigation, in	n my opir	nion, deat	h occurre	d at the time,	date and p	lace, and due	to the cause(s)
	To the To the To the To the Comp	M	29b. Signature and title of certifier	IMA)		29c.	License r	number			29d. Date	signed (Mont	h, Day, Year)	
)	4		* Athatha	nMI				DC	0536	15		Sep	tember	28, 2	004
	1		30. Name and address of person who				,								
	*		Aruan Surendar				Rockvi	lle	Pike	, #2	08, Ro	ckvil	le, MD	20852	
٠	Sta Registr		SEP 29 200		gistrar's Signa	19	Span	h							

			For State Registrar	State of Marylar		artment of H		,	giene Reg. No.2 () (74	32690
			1. Decedent's Name (First, Middle, L	ast)	0			2. Date of Dea Month	1.00	Year	3. Time of Death
	Physicia /Medic		William -	Townsheno	<u>l</u>				27-20		2.55PM.
	Examin		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, or	Location of De	ath	4c. County	of Death	
			Sligo Creek Nur			Takoma		· · · · · · · · · · · · · · · · · ·		tgome	
	Funeral		5. Social Security Number 6. 225-40-0461	Sex 7. Age (In yrs. 1		If Under 1 Year Months Days		8. Date of Birt (Month, Day Feb. 9,	v, Year) 1934	Count	ace (State or Foreign (IV) Lngton, DC
	Director	-	Usual Residence of Decedent					102.37	2301		ingcon, be
	ylanc		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10	d. Inside City Limits
	e Marita	cto	West Virginia Berkele	∍y F	alling	Waters					1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Count	ry?
	s 23e	rai	76 Mohican Way	<u> </u>		25419		/D // W	US.		1 - 1 - 1
	ter de	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? in, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black	- America k, White, e	
336	urs af	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1956	-58	1 ☐ Yes 2 ☐ No	Specify:		Specify:	Whit	.e
ğ	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23e or 28e-f ehow ther the Medical Evandrar must be nutilised at	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	ation	unding	16b. Kind of Bu	siness/Ind	ustry
2	thin 7 e. an "r	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	daning most of (VOIKING			
2	filed wi Hygien Sther th	Ç	8		Ref	rigeratio			HVA		
ğ	be fill	To Be	17. Father's Name (First, Middle, Las					lame (First, Middle,		B)	
Maryland 21215-0036	should ind Men s marke umatic	ို	Grafton Wilmot 19a. Informant's Name/Relationship		10h Maili	na Addraes (Street		e Mae Con		State Zie	Code
Ma	id 2 slith and 27 is r		Ann Rothgeb/ Si					ing Water	•		oode)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f ehow eny injury or other treumatic event, the Medical Evandrat must be notified at once.		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of matory or other plac		tember 30,	20c. Location - 0		wn, State
Ë	Pages nent of I ant: If its ury or o		1 Suburial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	Edgehil	.1	1 -		Charles To	own. W	est Virginia
Baltimore,	permit. Departm Importe eny inju		21. Signatur of Huneral Service Lic	riser/	Cemete	Name and Address	ss of Facility	s Funeral		•	
m	99 = 8		1 Abbort ///	Me -				s runeral .vd, W, Si			MD 20901
П			23a. Parts. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dear by one cause on each line.	th. Do not en	ter the mode of dyin	g, such as card	iac or respiratory ar	rest,		Approximate Interval Between
Z	Pnysician		Immediate Cause (Final disease or condition	- genera	li'20	od t	Selvil	ly			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of	0	0	0			
		<u></u>	Se uentially list conditions. if any, leading to immediate	b. Due to (or as a consec	uence of):	OUA 8	orde	Υ		-	
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		,						
ď.	exectin and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
8760,	cate be executed oblysician and the burial-transit	Physician/Medical		d							
9	ntifica ng ph s as th	Med	IF FEMALE:	riv.							
Вох	eath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Feta	al death 3	Ectopic pregnancy			23d. Date Mon	of deliver	y Day Year
0	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5L	Other (specify)					
٥.	that the de led by the a detached t		Part II. Other significant conditions	contributing to death but not re-	sulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?
ds,	uires tha signed Id be del	d by						1 □ Y	es 2 No	3 🔲 Proba	bly 4 Dunknown
Vital Record	w require been si should I	Completed						24a. Was	an 24b. W	/ere autop	sy findings available
Re	ysician: The lav is certificate has director, page 2	dmo						autop perfor	med? 🔒 de	rior to com eath? □ Yes :	pletion of cause of
ta		e)	25. Was case referred to medical				26. Place of D	1 ☐ Yes Death (Check only o			
_ <	Physici this cer at direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Othe	er: Wursing	g Home 5 ☐ Resid	lence 6 🗆 Othe	r (Specify)	
n of	Attending Physician: r death. sctor: After this certifica		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	y at k?	28d. Describe h	ow injury occurre	bd	
sio	death. ctor: A y the fu	cati	2 Accident investigat 3 Suicide 6 Could not	ha			Yes 2 □ No				
Division	al or Attending Phy after death. I Diractor: After this d in by the funeral d	ertification;	4 Homicide determine		nome, farm, st fy)	reet, factory, office		28t. Location (S City or Tow	Street and Numbe m, State)	or Hural	Houte Number,
	spitel	O	29a. Certifier Certifying	Physician: To the best of my kno	owledge, deat	h occurred at the tim	ne, date and ola	ace, and due to the	ause(s) and mar	nner as eta	ited
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Ex	aminer: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death o	curred at the time, o	date and place, a	nd due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	ſ	1 (1 .	29c. License	e number	:	29d. Date signed	(Month, D	ay, Year)
	11		1) un	mi IV I	ch	D 2	5405	3	9/28	100	1
	4+1		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type,	Print)	ALIE	47607	AKOMA	PAR	K
	1		SURESH KIKH	TAN M.D.	1610,	CHRRO	CHUC	11-20-1	MD 20	912	
Ę	Sta Registi	ite ar	30. Name and address of person which is the state of the	2004 32. Hagistrar's Sign	ature 5	Spork	200				
	J - "			/ /	/	. /					

			1 - For State Registrar	State of Marylan		artment of H tificate of L			iene •g. No.2004	32691
	Physici /Medio		Decedent's Name (First, Middle, Last) MAY	BERNADETT	Е Т	RAVIS		2. Date of Deat Month Sept.	Day Year 28, 2004	3. Time of Death 0800 M
	Examin		4a. Facility Name (If not institution, give s 7 136th Street	treet and number)		4b. City, Town, or Ocean	Location of Death		4c. County of Dea	cester
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9-20-	Year) 9. Bii	thplace (State or Foreign ountry)
70			Usual Residence of Decedent	10. 6	tv. Town or Lo					104 1-14 05 11
Aarvia	show	ō	10a. State 10b. County NY Suffol		und B					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the A	r 28a-	irect	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	ountry?
th with	23a o	al D	30 Brightwater 1	Rd.		117	789		USA	
Great Within 72 hours after death with the Marcland	Department of Health and Mental Hygiene. Important: if item 23a or 28a-1 show important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic evant, the Medical Evaruter must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🗷 o	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:	
	natura Ilcal E	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired,	ntion Juring most of work	kina	16b. Kind of Business	
6 Within	/giene. lar than " t, the Mu	Completed	Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		oo not use retired, emaker			Own Hom	e
	ad oth	Be	17. Father's Name (First, Middle, Last)	1 **				e (First, Middle, M		
should should	nd Me mark imatic	은	Michael Reil: 19a. Informant's Name/Relationship (Type	*	19b. Mailir	ng Address (Street a		Kate Re	City or Town, State,	Zip Code)
J Wie	n 27 is er trau		Kathy Blanton	Dgtr.					Beach, N	Y 11789
2 5 P	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ ☐	emoval from State	cemetery, cren	sition (Name of natory or other place	9)		20c. Location - City or	
li Pa	artmer ortant injury B.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	A		ton Mem. . Name and Addres	1	1-07	Mt. Sina	1, NY
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	Medical xaminer transit the burial-transit	edicai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	44	uence of): uence of):	POTIC CA	KÒIO VASO	ULAR	DISE/KE.	Interval Between Onset and Death
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S that	ned by e deta	by Ph	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
w requires	een sig							1 □ Ye	s 2 No 3 P	robably 4 🗹 Unknown
I The law requires that the	icate has b	Completed						24a. Was ar autops perform 1 Yes 2	prior to death? Mo 1 ☐ Yes	utopsy findings available completion of cause of
VILGI sician: T	s certif	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe		th <i>(Check only one</i> ome 5 □ Reside	nce 6 Other (Spe	CION JEME
nding Phy	within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho		5.15) Promis
DIVISION Is or Attending	s after de al Diracto ed in by th	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
ha Hosnii	in 24 hour he Funari pletely fills	edicai		ician: To the best of my kno ler: On the basis of examina and manner stated.		vestigation, in my op	inion, death occur	red at the time, da	ite and place, and due	e to the cause(s)
Ę.	To t	Ž	29b. Signature and title of certifier	logworth, M.	1.		06241		9d. Date signed (Mont	54
+	1.17		30. Name and address of person who co	4	m 23a) (Type,	Print) D. 20	3 Swow S	STI SNO.	W AKK, N	D, 21863
	Sta	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa		and I				

Westlake, Marie

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:20 A M ctober Westlake 6,2004 Marie Elizabeth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Lions Manor Nursing Home** Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 10, Birthplace (State or Foreign Country)
 OH 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F 301-24-9542 Vrs 75 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Allegany Cumberland 1.☐Yes 2☐No Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Furnace St. Apt. 103 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes Ž☐ No Specify: white ģ 3 ☐ Widowed ¥ ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than *na any injury or other traumatic event, the Medis once. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursina 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Sheldon Westlake Buelah Cooper Westlake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lesa Dutra daughter 68 Tyler Way Martinsburg WV 25401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/2004 MD Cumberland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23 F nt. Ent r the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r eart failure. List only one cause on each line.

Immediate se (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician i Oyears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown Part II_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENAU 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 Yes : After this certifical funeral director, r or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? examiner? 101 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attandii within 24 hours after death. To the Funerel Director: A investigation the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 6, 2004 30. Name and address of person who complete d cause of death tem 23a) (Type, Print) Cumberland, MD 21502 Seton Suite 201 904 Ober 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2260 Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** ALTHEA VIRGINIA WALCH P^{M} OCTOBER 2004 3:20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day Aug. 17 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Virginia 6. Sex **Funeral** 1 M 2 F 97 Yrs. 1907 218-30-8424 Aug. Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural", or itams 23a or 28a-f show seumatic svent, it e Madical Examilian must be natified at 1 Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 East 16th Street 21701 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: 3 ♥Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Depurtment of Health and Mental Important: If Item 27 is marked any injury or other traumatic avance. Joseph William Cordell Hattie Trittipoe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Edward Walch/Son 7918 Yellow Springs Road, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Clustered Spires Cemetery Oct. 12, 2004 Frederick, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liegnsae

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Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Struct

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Keeney & Basford Funeral Home 21. Signatur of Funeral Service License Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Completed by Physician/Medical esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) detached 9☐ Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 2 No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has perform 2/10 1 Yes illed in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 6 within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ustin 009689 8 POTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jr., M.D., 3 300 West Ninth Street, Frederick, MD 21701 <u>Austin Pearre,</u> 31. Date filed (Month, Day, Year) State OCT 1 4 2004 Maria -

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Marguerite Louise 8, 2004 Wilt October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Health Care Center Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 3, 1923 9. Birthplace (State or Foreign Country)
Maryland 6. Sex **Funeral** 1 □ M 2 7 F 218-38-0950 81 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 2.7 is marked other than "naturat", or items 23a or 28a-f show any injury or other fraumatic event, the Modical Examiner man be notified as any injury or other fraumatic event, the Modical Examiner man be notified as Frederick Maryland Adamstown 1 ☐ Yes 2 No Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2134 Ballanger Creek Pike 21710 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes XXNo White If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Evers Summers Iva Marguerite Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kelly L. Heffner, daughter 85-C Edward Lane, Charles Town, W. VA. 25414 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Oct. 12, 2004 Frederick, MD `4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility

Keeney and Basford PA Funeral Home

106 Fast Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive

Due to (or as a consequence of): Heart Failure **Physician** YEAVS /Medical Examiner tor Y eavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day 4 Pregnant at time of death Year 5 Other (specify) signed by the a P.O. 1 Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 3 Probably 1 ☐ Yes 4 | Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place f Death Check onl one Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D22037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Name: Wolfe Willis Baltimore, Maryland 21215-0036

Box 68760,	
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Vital Records	
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VII	sician: The law s certificate has b lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		D/O	ott		ath (Check only			
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	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of niner: On the basis of e and manner state	xaminati	vledge, deatl on and/or in	h occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the urred at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within Fo the complex	Me	29b. Signature and title of certifier	1-			29c. Licens	e number		29d. Date	e signed (Monti	h, Day, Year)
			DA4	1			Di	3251	8	10	18/04	
	20		30. Name and address of person who	completed cause of dea	ath (Item	23а) (Туре,						
	0		DR. ROBERT GUEI	DENET 21	WYAN	ID DR	IVE KEF	DYSVILI	E, MD	2175	66 / 30	01-432-222
	Sta		31. Date filed (Month, Day, Year) OCT 1 4 2004	32. Registrar	's Signatu	y /	parks		,			
	Registr	al	OOIT T LOUT		/-	1	, 20					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 4:16 Дм 04 ETHEL ALVAH WHITE 29 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F 87 Yrs Director 365-18-6590 4/5/1917 Michigan Usuat Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Show s 23a or 28a-f shortust be notified at 1 ☐ Yes 2X No Directo Somerset Deal Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11537 Hodson White RD 21821 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status other traumatic event, the Madical Examiner Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary **US** Government s 1 and 2 should be filed vil Health and Mental Hygie item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be R. Joseph Charlebois Olive Beauchamp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11537 Hodson White RD Deal Island, MD 21821 Barbara Wallace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H important: If ite any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD Old St. John Cemetery 10/6/04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licenses 22. Name and Address of Facility The Burbage Funeral acquel eno 234. Part 1. Enter the disease, or complications that caused the deeth. Or not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myourdie 400/5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760 Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 22 No 1 ☐ Yes 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death Check onlone Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ō in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death. Director: After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 45KIL-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ellhory Drug Ber 31. Date filed (Month, Pay, Year) State

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Registrar

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		-	For State Registrar	State of Maryla		artment of H rtificate of L		Jental Hygie Reg.	2001	32697
	Physicia	an	Decedent's Name (First, Middle, Last)	V				2. Date of Death Month	Day / Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	101	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 187-24-0697	7. Age (In yrs M 2□F 73	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye) Feb. 17,	9. Bir 2931 Per	thplace (State or Foreign ountry) Insylvania
	g	or	Usual Residence of Decedent		city, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the N 3a or 28a-1 I be notifi	i Director	10e. Street and Number 2329 Coon Club		es cinilii	10f. Zip Code 2115	7		Citizen of What Co	buntry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. de dither than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event. Ite Madical Examiner must be notified at	by Funerai	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in the Armed Forces? 1		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🌠 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whit Specify: [V	
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Mary	0 60 00 00	-	19a. Informant's Name/Relationship (Type Margaret M. Youn					ral Route Number, C. Westmin		
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)	To 1 with To 1	Σ	29b. Signature and title of certifier Will. 411	MO		DDD	number 158(3-		Date signed (Mont	n, Day, Year)
	7		30. Name and address of person who co	mpleted cause of death (Ite	. 1	tonnete	r MD	21157	,	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	*	Some				

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	/Medic		ELLOISE						EN	(D - 1)	OCTOBE		//	2004	177/ M
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Jeath The 2	era		1. Marital Status		12. Was Dec	edent Ever in	n U.S. 13.	Was Dec		ispanic Origin? (S n, Mexican, Puer	Specify	Yes or No-		14. Race - Am		ian,
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S Regis	tate		31. Date filed (Month)	(32. F	legistrar's Si										

			For State				-				nd Me	ntal Hyg	giene	10 m	
			1. Decedent's Name	TTEM #2	&26 PER P	HY C8	36 TO/	45/15/	$\mathfrak{J}P$	eath	1.0	F	leg. No.	Unh	32700
	Physici /Medic		Rone	14	Bacos	1						Month	Day	Year 200	1 1110 Au
	Examin		4a. Facility Name (If	not institution, give	street and number)	4		4b. City, To	wn, or L	1	Death			ounty of Dea	ath Cit
			Univer	SITT OF	Marylar		edica/	lé Lindou 1	5a				K	ei ltin	nove City
	Funeral Director		5. Social Security Nu	1	ex 2□F 7. Ag	je (In yrs. la	3 Yrs.	If Under 1 Months		2. Date of Death On Control of Death On Contro					
			373-34-927 Usual Residence of I	Decedent							J	an. 12	, 193	Nor	th Dakota
	show	_	10a. State	10b. County			, Town or Lo	cation							
	the M	Director	MD 10e. Street and Num	Prince G	eorges	Laur	eT	10f, Zip C	- 4 -				10- 00-		24
	with 3a or	Ö													ountry?
	death	Funeral	11. Marital Status	dford Ct	12. Was Decedent Armed Forces			Vas Deceder)707 nt of Hisp	anic Orig	in? (Speci	fy Yes or No-		. Race - Am	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It man 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event. It a Madical Examiner must be notified at	by	1 ☐ Never Marrie		1 ∰Yes 2 ☐ If Ye s, Give Year or Dates:		22-	Yes 2Ê			, rugito Ai	can, etc.)	S	-16	
5-0	72 ho natur	Completed	(Specif	15. Decedent's Ed fy only highest gra	lucation de completed)		(Give	lent's Usual (kind of work	done dui	on ring most	of working		16b. Kind	of Business	/Industry
121	within ene. than *	dmo	Elementary/Secon	ndary (0-12)	College (1-4or	5+)		oo NOT use esman	retired)				WSS	E	
	filed Hygi other	a	17. Father's Name (F	First, Middle, Last)					1	8. Mother	's Name (i	First, Middle,			
/lan	uld be Venta Nrked Ntic ev	To B	Ralph B	Bacon						Vi	iolet	Orser			
Maryland	2 sho s and l is ma		19a. Informant's Nar		**								•		Zip Code)
	1 and Health am 27		20a. Method of Dispo	ealey/Dau osition	gnter	20b. Pl	8805 ace of Dispos metery, cren								Town State
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. It a Magnes.		1 ☐ Burial 2 ☐		Removal from State					1					
alti	permit. F Departmo Importar any injur		21. Signature of Fun			MG.	Vets C			of Facility	Flec	y k Funer	chel ral H	ome Tr	n, MD
8	995.	(Kom	la Ste	wart		76	01 Sat	dy S	Sprin	ig Rd	. Laure	e1, M		
	Physician		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	Final	olications that cause one cause on each i	the death	Do not ente	or the mode of	of dying,	such as c	ardiac or r	espiratory arr	est,		Interval Between Onset and Death
	/Medical Examiner			ſ	Due to (or as	a consequ	ence of):								
	ed sit	iner	Sequentially list con if any, leading to immorause. Enter Under Cause (Disease or in	nditions, mediate flying	Due to (or as	a consequ	ence of):								
_6	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) La		c Due to (or as	a consequ	ence of):								
58760,	te be e ysiciar ne buri	edical		l	d										
_	ing ph		IF FEMALE:												
.O. Box	ires that the death certifi signed by the attending I I be detached for use as	Physician/M	23b. Was decedent in the past 12 n 1 Yes 2 N 9 Unknown	nghths?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic preg Other <i>(spec</i>					230		
٥,	requires that the een signed by th hould be detache	by Pł	Part II. Other signific	cant conditions c	ontributing to death b	ut not resu	lting in the un	iderlying cau	se given	in Part I.		23e. Did tol	bacco use	contribute to	the cause of death?
ord	w require been sig should b											1 🗆 Ye	es 2 🗆 i	No 3 P	robably 4 Nonknown
of Vital Records,	law as b 2 si	Completed									_	autops	SV.	prior to death?	completion of cause of
/ita	ysician: The is certificate hadirector, page	Be C	25. Was case referre	,					2	6. Place	of Death (_		
of \	Physic this o	၉	1 ☐ Yes 2 ☑	40	Hospital:		R/Outpatien		Other:						cify) UMMC
on	Jing J After funer	tlon	27. Manner of Death 1 Natural	5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M 28c	lnjury at Work? 1 ☐ Ye			d. Describe ho	ow injury o	ccurred	
Division	Attandi r death actor: A by the fi	ifica	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e, Place of In	ury - At hor	me, farm, stre					. Location (St	reet and N	lumber or Ri	ural Route Number,
Ö	ital or rs afte al Dir	Certification:			building, et										
	To the Hospital or Attano within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one)	1 Certifying Ph 2 ☐ Medical Exam	ysician: To the best niner: On the basis of and manner st	f examinati	vledge, death on and/or inv	occurred at estigation, in	the time, my opin	date and ion, death	place, and occurred	due to the ca at the time, d	ause(s) an ate and pl	d manner as ace, and due	s stated. a to the cause(s)
	To To T	Σ	29b. Signature and t	title of certifier	1	-nD		29c. L	icense n	umber 176	435	K15209	9d. Date s	igned (Mont	h, Day, Year)
	10		30. Name and addre	ss of person who	completed cause of c	leath (Item	23a) (Type, I	Print)			1		2010	7 1	Deptmentof
	Ψ		Ko	ffi I	< la 2	250	Ju Gr	eene ?	st.	Bu	ltin	are 1	ND	2170	1 Anesthesia
	Sta Registr		31. Date filed (Month			ar's Signati	La	1		4					
	3		U	ICT 1 5 21	JU4 / 724			1300	cho						

		1 - State Registrar AMEND ITEM 1. Decedent's Name (First, Middle, Last)	State of Maryland #5 PFR INF G83				2. Date o	Reg. N	2004	3. Time of Death
Physicia /Medic		Shirley	М.	· · · · · · · · · · · · · · · · · · ·	Bake		Month OCTOB		ay Year	2.21
Examin	er	4e. Facility Name (If not institution, give s			4b. City, Town, or			4	c. County of Dea	ath
unoval		GOOD SAMARI 5-Social Security Number 6. Sex			BALT I If Under 1 Year	If Under:		f Birth		rtholece (State or Forei
uneral irector		Usuel Residence of Decedent	M 2DXF 57	Yrs.	Months Days	Hours		Birth , Day, Year 25–46		rthplece (State or Foreign country) Md.
Mot W		10a. State 10b. County	10c. City,	Town or Loc	ation					10d, Inside City Limit
in in in	ctor	Md. NA		Bal	timore					1X Yes 2 □ N
in Typerie. do other than "natural", or items 23s or 28s-f show event, the Madical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code	20		10g. C	itizen of What C	*
234	erai	4526 Northwood Dr	Was Decedent Ever in U.S.	12 14	2123			Na	USA 14. Race - Am	
Then	Funerai	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			n, Mexican	gin? (Specify Yes o , Puerto Rican, etc.)	Black, Whi	
E KE	1 by	3 X Widowed 4 □ Divorced	If Yes, Give ** Year or Dates:	1	☐ Yes 2∏ No	Specify:			Specify: B	lack
natu	Completed	15. Decedent's Edu (Specify only highest grade		(Give k	ent's Usual Occupa	lurina most	of working	16b. l	Kind of Business	*
than the Man	duo	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>0 NOT u</i> se retired, Cher)		Ba	ltimore	Schools City Publi
office of the	0	12th grade 4 17. Father's Name (First, Middle, Last)	yrs	100	01102	18. Mothe	r's Name (First, Mic			CILY LADII
is marked o	To B	Lewis	Jackson				Rosa		Black	
= ~ =		19a. Informant's Name/Relationship (Ty)					r or Rural Route Nu			
important: If item 2 any injury or other		Lolita Marcucci 20a. Method of Disposition	Daughter 20b. Pla	ce of Dispos	ition (Name of		Baltimon Date		d. 2120 -ocation - City or	
ry or		1X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	retery, crem Zion (atory or other place		10-19-04	T.:	ansdowne	5M
y inju		21. Signature of Funeral Service License			Name and Addres				re, Md.	21202
any ii		France	(Jeans	Ma	arch F.H.	East	: 1101	E. No	orth Ave	21202
hysicien and the burial-transit	icai Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		UIINIA					
gned by the attending poe detached for use as	by Physician/Med	was decement pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown Part II. Other significant conditions con	3c. If yes, outcome of pregnanc 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown tributing to death but not result	éath 3⊡l th 5⊡ ing in the un	Ectopic pregnancy Other (specify)	n in Part I.		—————————————————————————————————————		ivery Day Year o the cause of death?
been si should I	etec	30/3/3	TODIEUM	_				-		
SC	Completed						24a. W	utopsy adormed?	prior to death?	utopsy findings available completion of cause of 2 1 No
certifi	Be	25. Was case referred to medical examiner?	ospital:		Othe		of Death (Check or			
After this certificate aften after this certificate after the funeral director, pages	on: To	1 Yes 2 Ho	1 Minpatient 2 LE	VOutpatient 8b. Time of Injury	3 DOA 28c. Injury Work	' 4□ Nur at ?	sing Home 5 R		6 Other (Spe	icity)
To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre		′es 2□N	28f. Locatio	n (Street a Town, Stat	nd Number or R e)	ural Route Number,
Funeral stely filled	edicai C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of my knowler: On the basis of examinatio and manner stated.	edge, death n and/or inve	occurred at the time estigation, in my op	e, date and inion, deat	place, and due to the control of the	he cause(s	and manner as d place, and due	s stated. e to the cause(s)
го the	Mec	29b. Signature and title of certifier	and mailler stated.		29c. License	number		29d. Da	ate signed (Mont	h, Day, Year)
1		F ()	MD		755	00	0	1	-	• ,
	1	30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type. P	rint)			100	IUDA	2/239.
1		51. 7.	0,5601 Lo	LH RA	VEN RI	U 🗠	RALTIM	La RS	111.	21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** October 14, 2004 Jr. РМ Martin Raner 4:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Month, Day Year November 1, 1924 Months 1**⊠**M 2□F Yrs. 79 Director 219-18-7294 MD. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mardical Exercitors. 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo **Funeral Director** MD. Baltimore Middle River 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4031 Issacs Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: White 1 ☐ Yes 2 No Specify: Specify Completed by 3 ⅓Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Eastern Stainless Steel Manager 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martin Bauer Catherine Schlicht ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Parker daughter 4031 Issacs Road, Middle River, MD. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1X Burial 2 □ Cremation 3 □ Removal from State Garrison Forest VA Cem. 4 Donation 5 Other (Specify) 19, 2004 Owings Mills, MD. Signature of Funeral Service Licenses ^{22, Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Severe cardio my opathy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 🗌 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 1 ☐ Yes _2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Diractor 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after 24 hours a 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 125 205 Etaber 14, 200x MO

Box 68760.

P.0.

Division of Vital Records.

Registrar

31. Date filed (Month, Day, Year) OCT 1 5 2004

.R.Le.

A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBMC

32. Registrar's Signature

6601 N. Charles Street

Towson, Md. 21204

DHMH 17 Rev 1/2001

Registrar

			FOI			alth and Mental H	ygiene				
1 - State Registrar AMEND TTEM #16a PER FH C836 GOT/FIGATE, Of Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death											
	Physicia	an				Month	Day Year	3. Time of Death			
	/Medic	al	JOAN TSOWE 4a. Facility Name (If not institution, give street and nun		4b. City, Town, or Loc	OCTOIS	ER 12 20 4c. County of Dea	-			
	Examin	er					N/A	261			
	Funeral	n 1	JOHNS HOPKINS BAY VIZ 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year If	Under 24 Hrs. 8 Date of E	irth 9. Bi	rthptace (State or Foreign			
6	Director		228-80-3615 1□M 2 X F	67 Yr	s. Months Days F	Hours Min. (Month, L	Day, Year)	Maryland			
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	- Landing						
	shov	5	10b. County Iaryland Baltimore		kesville			10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	the N	ect	10e. Street and Number		10f. Zip Code		10g. Citizen of What C				
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-f show or other traumatic event, it a Medical Evantinal trained to collife and or other traumatic event, it is Medical Evantinal trained to collife and	Funeral Director	4535 Mary Knoll Road		21208		USA	ountry.			
	death	era	11. Marital Status 12. Was Dece	dent Ever in U.S.	13. Was Decedent of Hispa	nic Origin? (Specify Yes or N	lo- 14. Race - Am				
9	or its		Armed For 1 Yes If Yes, Giv	2 [\$] No	_	Mexican, Puèrto Rican, etc.)	Black, Wh				
5-0036	urai',	d by	3 Widowed 4 Divorced Year or Da	ites:			Specify: W				
15-	"nate	Completed	15. Decedent's Education (Specify only highest grade completed)	(6	ecedent's Usual Occupation Give kind of work done durinife. DO NOT use retired)	n ng most of working	16b, Kind of Business	s/Industry			
2121	within ene. than "	dmc	Elementary/Secondary (0-12) College (1 N / A	-4or 5+)		WORKED					
	Hygi Hygi Sther ent, L		17. Father's Name (First, Middle, Last)			. Mother's Name (First, Midd	le, Maiden Sumame)				
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, It e Mi	To Be	Charles Coleman Bowes	rs	Ma	arion Alice	Baker				
ary	should and Men s marke umatic		19a. Informant's Name/Relationship (Type, Print)			Number or Rural Route Num					
	1 and 2 Health a		Ori Natividad/ Care	Provider	7215 York F	Rd Baltimore	e, Marylan	d 21212			
ore	of He of He if item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5	20b. Place of D cemetery,	hisposition (Name of crematory or other place)	10/18/04	20c. Location - City o	r Town, State			
Ĕ	Pag ment ant: l		*4 □ Donation 5 □ Other (Specify)	Sacred	Heart of 3		Dundalk,				
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		22. Name and Address of 5240 Reist	r Facility Chatman erstown Rd	n-Harris F Baltimore	uneral Hom, , Md 21215			
9.5	A. P.		23a. Part. Enter the disease, or complications that can shock, or heart failure. List only one cause on each	aused the death. Do no	t enter the mode of dying, s	uch as cardiac or respiratory	arrest,	Approximate Intervat Between			
	Physician		Immediate Cause (Finat disease or condition	HYDRA	-TION			Onset and Death			
1	/Medical Examiner		resulting in death) Due to (or as a consequence of	ii.			VI-0			
17 38	Laminer	_	Sa uentially list conditions b. Due to	YSPHAG or as a consequence of				YFS			
-	ted nsit	nIne	cause. Enter Underlying Cause (Disease or injury	Chil	SYNDR	245		1/25			
,	be executed sician and burial-transit	Examiner	that initiated events c. Due to (or as a consequence of							
8760	death certificate be executed e attending physician and od for use as the burial-transit	dical	d								
9	ntifica ng ph as th	Medi	IC SCHAAL C.								
Вох	leath certific attending p I for use as	an/h		come of pregnancy irth 2 Tetal death	3 Ectopic pregnancy		23d. Date of de Month	Day Year			
.O.	ne des the at hed fo	Completed by Physician/Me	1	ant at time of death	5 Other (specify)		World	Day 18a1			
Δ,	that the de ed by the detached	Ph	Part II. Other significant conditions contributing to de	eath but not resulting in t	he underlying cause given in	n Part I. 23e. Dio	I tobacco use contribute t	to the cause of death?			
of Vital Records,	w requires that the s been signed by th : should be detache	d b	_	_	SUFFICIER		Yes 2 ⊠No 3 P	robably 4 Dunknown			
COI	> 11 (5	lete	TRACHEDSTOHY I			/	s an 24b. Were a	utopsy findings available			
Re	The la te ha: age 2	ошь	A			Dec	formed? death?	completion of cause of s 22No			
ita	en: 'tifica tor, p	ø	25. Was case referred to medical	CIV 03 1911	FEEDIN 26	I ☐ Yes 3. Place of Death (Check only		2/2/10			
>	nysici nis ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 X	npatient 2 ER/Outp	atient 3 DOA Other:	4 ☐ Nursing Home 5 ☐ Re	sidence 6 ☐Other (Spe	ecify)			
0 1	ng Pt fter th		27. Manner of Death 1 SNatural 5 ☐ Pending (Mont	of Injury 28b. Tir h, Day Year) Inju	ne of 28c. Injury at		how injury occurred				
Sio	tendii eath. ior: A the fu	cati	2 Accident investigation			2 No					
Division	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	Certification:	determined 286. Place	of Injury - At home, farming, etc. (Specify)	n, street, factory, office		(Street and Number or Rown, State)	lural Route Number,			
	ospite hours unere		29a. Certifier (Check only 2 Medical Examiner: On the ba	best of my knowledge,	death occurred at the time, of	date and place, and due to the	e cause(s) and manner a	s stated.			
	the H hin 24 the F mplete	Medical	one) and manr	ner stated.	29c. License nu		29d. Date signed (Mon	\"\"			
	7. × 5.0	3	29b. Signature and title of confrier			1383	- '				
			30. Name and address of or on who completed caus	e of death (Item 23a) (To	vpa Print)	HOPLEIASE	BAYVIEW	DCIBELE			
			30. Name and address of the n who completed caus W. 75. GREENO (LC)	3H II SA	BALT	TO ORDER	10 212	24			
	Sta	te	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	Ś.	, ,		/			
3.5	Registr	ar	OCT 1 5 2004 Sent	va 19	Sparker						

		1	1 - For State Registrar		State of	Maryla	_		nt of He te of D		Mental H	ygiei Reg.			
	o		Decedent's Name (First,)	Middle, La	st)						2. Date of	Death	Em Id 1.	14	3. Time of Death
н	Physici		KEVIN		ROGER	7	BAILEY				OLTOB	= 0	,	rear	C732 AM
	/Medic Examin		4a. Facility Name (If not inst				,,	4b. City	, Town, or I	ocation of Dea			4c. County of		7,72 /
1	Examin	Ç.	NURTHWEST	_	HUSCITA	A-7			EANDI	ALLSTON	~		BALT		0 5
	Funeral		5. Social Security Number	6. 9	1.		s. last birthday)	If Unde	er 1 Year	If Under 24 Hrs	8. Date of	3irth		9. Birthp	lace (State or Foreign
	Director		218-68-0721	1	IM 2□F	49	Yrs.	Months	Days	Hours Min	8. Date of 1 (Month, June	13.	1955 I	Coun	ifry)
	P		Usual Residence of Decede												
	rylan how		10a. State 10b. C	ounty		10c. C	City, Town or Lo	cation						1	0d. Inside City Limits
	Ma Ha	Director	Maryland	Ba1	timore		Catons	vill	e						1 ☐ Yes 2 ☒ No
	or 28	ire	10e. Street and Number					10f. Z	p Code			10g.	Citizen of Wh	at Coun	itry?
	th wi		35 Dunmore	Road					2	1228			U.S.	۸.	
	dea dea	Funerai	11. Marital Status		12. Was Deced		U.S. 13.	Was Dece			Specify Yes or to Rican, etc.)	No-	14. Race		an Indian,
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. Id other then "neturel", or Items 23a or 28e-1 show event, the Medical Evertified at	by	1 X Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 ∐Yes If Yes, Give Year or Da	2 🔯 No 9		1 ☐ Yes		Specify:	10011,000.		Specify:	Whi	
Ō	2 ho	Completed	15. Dec	edent's E	ducation		16a. Dece	dent's Usi	ual Occupat	ion		16b	. Kind of Bus	ness/Inc	dustry
218	thin 7 9.	pie	Elementary/Secondary (0	-	ade completed) College (1-	4or 5+)	life.	DO NOT	use retired)	iring most of wo	nking				
21	d wit gient grent er th	No.	12		1+		D	isab	1ed			į			
p	e file al Hy l oth	Be (17. Father's Name (First, M.	ddle, Last)					18. Mother's Na	me (First, Midd	lle, Maio	len Sumame,)	
Maryland	2 should be filed within n and Mental Hygiene. r is marked other then "raumatic event, the Men	10	George Roge:	r Bai	ley.					Betty	Clary				
a	2 sho and f is ma		19a. Informant's Name/Rela	itionship (Type, Print)		19b. Mailir	ng Addres	s (Street ar	nd Number or A	ural Route Nun	nber, Cit	y or Town, S	ate, Zip	Code)
	D = 2 :		Jacki Gallia	an (Sister)		A STATE OF THE PARTY OF THE PAR			e Road	Catonsv	i11€	, MD 2	2122	8
ore	es 1 of He fiter roth		20a. Method of Disposition 1 Burial 2 ☐ Crema	tion 3 F	Dameural from S		Place of Dispo cemetery, crei	sition (Na natory or	me of other place	, !	Date	20c.	Location - C	ity or To	wn, State
Ĕ	Pages nent of I ent: if its ury or o		`4 □Donation 5 □Oth				udon Pa	rk C	emete:	ry 10-	16-2004	Ва	ltimor	e, I	Maryland
Baltimore,	permit. Pages 1 ar Department of Hea Importent: if item ' eny injury or other once.		21. Signature of Funeral Se	rvice Lice		√ 00€	369 Wi	Name a	nd Address Fune:	of Facility	e of Ca	tons	ville,	In	c. and 21228
			23a. Part1. Enter the disea shock, or heart failure	se, or com									.re, Ma	ITYL	Approximate
	Dhysisian		Immediate Cause (Final	List only	one cause on ea		4								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-	a. Due to /c	Cardia or as a conse		vies	f						20 minutes
	Examiner			- 6	Duo to (c	_		arr							7.
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J	b. Due to (c	or as a conse	equence of.	000	259	-					20 minutes
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	1		heir	CXIA								20 minus
oʻ.	exection and and rial-tr	Еха	resulting in death) Last	- 1	Due to (d	or as a conse	equence of):								
68760,	ificate be executed g physician and as the burial-transit	edicai		·	d,										
68	:= D 0												1		
Вох	The law requires that the death certi tle has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, outo			75					23d. Date	of delive	ry
m.	death e atte d for	icia	in the past 12 months¹ 1 ☐ Yes 2 ☐ No		4☐Pregna	nth 2 □ Fe ant at time of		Dectopic portion of the control of t	regnancy pecify)				Mont	1	Day Year
0	that the de led by the a detached t	hys	9 🗆 Unknown		9□ Unkno	wn									
٦,	es tha igned be del	by P	Part II. Other significant co	nditions	contributing to de	ath but not re	sulting in the u	nderlying	cause giver	in Part I.	23e. Die	tobacc	o use contrib	ute to th	e cause of death?
Records,	w require been sig should b										1 [Yes	2 □ No 3	☐ Prob	ably 4 Unknown
000	s bee	Completed									24a. Wt		24b. We	re autop	osy findings available
R	The lay	Шo							-		pe	topsy formed:	? dea	ath?	npletion of cause of
Vital		a	25. Was case referred to m	edical						26 Place of De	ath Check only	2 🗆 1	NO IL] Yes	Zag No
>	Physicien: this certificaral director, p	OB	examiner? 1 ☐ Yes 2 🔀 No		Hospital:	patient 2[☐ ER/Outpatier	nt 3□ D	Other		Home 5□Re	-	6 ∏Other	(Specify	1
of	ra ‡	H:	27. Manner of Death		28a. Date of	f Injury	28b. Time of		28c. Injury a				jury occurred		/
ion	nding f ath. r: After e funer	atio		ending vestigatio		i, Day Year)	Injury	M		es 2 □No					
Division	Attendi r death. ector: A by the fu	ific		ould not b	280. Place	of Injury - At	home, farm, str	eet, facto	y, office					or Rura	Route Number,
Ō	al or Attendi s after death. Il Director: A ed in by the fu	Certification:	- Litothicide		pullain	g, etc. (Spec	niy)				City or T	UWII, Si	a.0)		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (29a. Certifier (Check only one)	tifying Pl dical Exa	nysician: To the l miner: On the ba	sis of examir	nowledge, death nation and/or in	n occurred vestigation	at the time n, in my opi	, date and plac nion, death occ	e, and due to thurred at the time	e cause e, date a	(s) and mann and place, and	er as sta d due to	ated. the cause(s)
	To the To the	Me	29b. Signature and title of c	ertifier	Section 111841111			29	c. License	number		29d. [Date signed (Month, L	Day, Year)
	\wedge		Rush	o-	miD				DA	0 5973	6	,) sho is		1 2004
	1 5		30. Name and address of po	rson who			em 23a) (Type,	Print)	V 0	- 1 (1)		6	1000		2, 2004
	`		DEBURAH	WAT	TSOM .	m.D.	540	(0	40 (0	DRT P	VAD A	ZAN D	ALLSTON	N	MARYLAMO
٠.	Sta	te	31. Date filed (Month Day,				nature of							7	
•	Registr	ar	001 1	2 40	UT JULY	we s	a popular								

			1 - For State Registrar	State of Ma	-		rtment of H tificate of I			•		2001.	32706
	Physici	an	1. Decedent's Name (First, Middle, Last)	OMAS BEA	\1	_				Date of Dea Month	ith Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give stre		1		4b. City, Town, or	r Location		<u>Octobe</u>			
	Exami	iei	Oak Crest Village				Parkvi	lle			Reg. No. 2 Death Day Year 3. Time of the Day Year 12, 2004 9:05F 4c. County of Death Baltimore Sinth Day Year 9. Birthplace (State or Country) 1, 1919 Maryland Tod. Inside City 1 Pes 100. Inside City 1 Pes 100. Citizen of What Country? USA 10- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Dept of Navy 16, Maryland 20c. Location - City or Town, State Baltimore, Maryland 20c. Location - City or Town, State Baltimore, Maryland 2121 arrest, Approximate Interval Betwonset and Double State 100		ore
	Funeral Director		5. Social Security Number 6. Sex 216-10-6949 XX		(In yrs. last birt	hday)_ Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birti (Month, Day arch	, Year) , 191	9. Birth Cou 19 Mar	place (State or Foreign ntry) Yland
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	ation						10d. Inside City Limits
	Marylé f sho	ō	Maryland Baltimore		Parkv:								1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number		Tarky.	TITE	10f. Zip Code				10g. Citiz	zen of What Cou	
	h with		8800 Walther Blvd Ap	ot 3201			21234	1			L	JSA	
Marylahd 21215-0036	n 72 hours after death with the Maryland "naturel", or Items 23e or 28a-f show solical Examiner must be recitified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Education Armed Forces? 1	10777	lf	/as Decedent of H Yes, specify Cuba □ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	ispanic Or in, Mexica Specify	n, Puerto Ric	y Yes or No- an, etc.)		Black, White	etc.
5-0	72 ho	Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a.	Decede (Give k	ent's Usual Occupa	ation during mos	st of working		16b. Kir	nd of Business/Ir	ndustry
2	be filed within 72 ho tal Hygiene. d other than "natui event, the Medical	mpl	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. D	ONOT use retired Analyst	•			Don	+ of Na	
22	e filed v Il Hygie other t	e Co	12 17. Father's Name (First, Middle, Last)				Allaryst		er's Name (F	irst. Middle.			v y
an		To Be	George Beal					Anı	na Kli	shis		•	
ary	E E	-	19a. Informant's Name/Relationship (Type,	Print)	19b.	Mailing	Address (Street	and Numb	er or Rural R	oute Numbe	r, City or	Town, State, Zi	Code)
_	1 and 2 Health a lem 27 is		Helen S Beal	Wi							rkvi	lle, Ma	ryland 2123
Baltimore,	m Q		20a. Method of Disposition XXXBurial 2 ☐ Cremation 3 ☐ Rem	oval from State	1		ition (Name of atory or other plac		Date		20c. Loc	cation - City or T	own, State
Ξ̈́	permit. Page Department of Important: If any injury of		'4 □Donation 5 □Other (Specify)		Woodla		Cemetery		10/15/0		Bal	timore,	Maryland
Bal	permii Depar Impor any ir	1	21. Signature of Funeral Service Licensee	Non	, b. /	22.	Name and Addres						
			23a. Part1. Enter the disease, or complicat	tions that caused t	he death. Do n	ot ente	r the mode of dyin					ore, rary.	Approximate
A	Physician	k i	shock, or heart failure. List only one Immediate Cause (Final	11		-						ļ.	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence	1 C							
1	Examiner		Sequentially list conditions b	Perio			Vascu	lor	D	seas	2		
	pe tis	iner	Sequentially list conditions, if any leading 1: immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as à	consequence o	of[ii							
	cate be executed physician and the burial-transit	Examin	that initiated events c resulting in death) Last	Due to (or as a	consequence o	of):							
8760,	be exician	a E				.,							
687	phy:	edical	d.				-						_
О. Вох	The law requires that the death certificate has been signed by the attending tyage 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetel death		Ectopic pregnancy Other (specify)				2.		
<u>α</u>	that the de ted by the a		Part II. Other significent conditions contri	outing to death but	not resulting in	the un	derlying cause give	en in Part	l.	23e. Did to	bacco us	se contribute to t	he cause of death?
rds	quires in sign uld be	ed by	Advanced 1	flzhei	moris	C	isease			1 □ Y	es 2 □	No 3 ☐ Prol	oably 4 Minown
Vital Records,	aw requir is been si 2 should l	Completed								24a. Was a		24b. Were auto	ppsy findings available
Ä	The lav	E								perfor	med?	death?	
/ita	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?						e of Death (C	heck only or	1e)		
of \	S 0 10	မ	1 ☐ Yes 2 ☐ No Hos		t 2 ER/Out			4 L N					۶)
Š L		lon:	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Ye <i>ar)</i> 28b. T	ime of njury	28c, Injury World M 1	/at k? Yes 2. □		. Describe n	ow injury	occurred	
Division	ten leat lor: the	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	v - At home, far	rm. stre		163 2		Location (S	treet and	Number or Rura	al Route Number.
Di≤	after after Direct	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	, 0,10	on, raciony, comes			City or Tow			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of On the basis of and manner stat	examination and	, death d/or inve	occurred at the timestigation, in my of	ne, date ai pinion, dea	nd place, and ath occurred	due to the d at the time, d	ause(s) a late and	and manner as s place, and due t	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c. License	e number		2	Day, Year)		
	1		I an mon	ico			D58	6 4	6		10	-13-04	
	4		30. Name and address of person who comp			Туре, Р	mna		mo-				
	V			Booleva			Parkvill	le	MO	212	34		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Hegistrai	's Signature	1	. ·						
DH	HMH 17 Rev 1/2		OCT 1 5 2004	32. Registra	15 1	900							

ORIGINAL

DS			1- State Onpend Item 23 tate of Maryland Peperment of Registrar Certificate of	sigalinang M		ene	e comment	32707
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
	/Med	ical	LeeRoy F. Baublitz 4a. Facility Name (If not institution, give street and number) 4b. City, Town	m, or Location of Death	October	4, 20 4c. County		1517 p ^M
	Exami	ner		minster		Carr		
6	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth	(ear)	9. Birthpi	ace (State or Foreign try) Land
17	Director		215-20-9297 81 Yrs.	73 110013 111111	Oct 20,	1922	Mary	land
	laryland show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10	Od. Inside City Limits
	the Man 28a-f sh	tor	Maryland Baltimore	Hamp	stead			1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number 10f. Zip Cod		100	g. Citizen of V		try?
	036 rurs after death with the Maryla et', or tems 23e or 28a-f shov Examiner must be nutified at	era	18700 Upper Beckleysville Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent C	21074	noify Voc or No		ISA e - America	an Indian
	after dea	by Funeral	1 ☐ Never Married 2 ☐ Married 112 Tyes 2 ☐ No	of Hispanic Origin? (Spe Duban, Mexican, Puerto	Rican, etc.)		k, White, e	etc.
	5-0030	d by	3☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII 1 ☐ Yes 2☑ 1	No Specify:		Specify	v: \[\frac{1}{2}\]	white
	15-(n 72 t	lete	life DO NOT use re	one during most of working	ing 16	Sb. Kind of Bu	usiness/Ind	ustry
	212 d within	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Owne			Auc	ction	House
	Maryland 21215-0036 at 2 should be filed within 72 hours after death with the Maryland th and Mental hygiene. It is marked other then "neturel", or items 23e or 28e-f show treamatic event, the Madical Examiner must be natified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			10)	
	yla nould h i Ment narke	To Be	Harvey L. Baublitz		7. Osborn			
	Mai od 2 st tth and 27 Is n		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str. 18710 Upper					
	S 1 ar of Hea item 3		20a. Method of Disposition 20b. Place of Disposition (Name of	f place)		c. Location -		
	Page Page ment c		1½ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Pleasant Grove (3.0.40	9/2004	Reist	ersto	wn, MD
	Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filled within 72 ho Department of Health and Mould be filled within 72 ho Important: If item 27 is marked other than "neture any jury or other treumstic event, the Modical once."	1	21. Signature of Fun rai Service Licensee 22. Name and Ad		Eline Fu			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of c	uth Main St			D 210	74 Approximate
			shock, or heart failure. List only one cause on each line.	dyllig, such as cardiac o	n respiratory arres	ι,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Anaphylactic Reaction Due to (or as a consequence of):				-	
	Examiner		Sequentially list conditions.					
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	'60, be executed sician and burial-transit	Exan	that initiated events c					
	8760, cate be excohysician at the burial		d					
	K 68 ertifica ling ph	Physician/Medical	IF FEMALE:					
	Box 68 eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months? 1 Pregnant at time of death 5 other (specify			23d. Dat Mor	e of deliver	y Day Year
	P.O. B that the death ed by the atter detached for	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	/				
	IS, P	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobac	cco use contr	ibute to the	e cause of death?
	cord w require been sij	ted	Atherosclerotic Cardiovascular Disease		1 Tes	2 □ No	3 Proba	ıbly 4.⊠Ünknown
	of Vital Records, Physicien: The law requires tribis certificate has been signeral director, page 2 should be c	Completed by			24a. Was an autopsy performe	24b. V	Vere autop	sy findings available spletion of cause of
	tal Roman The Interpretate has precised by page		25. Was case referred to medical	00 Pl (P 1	19€ Yes 2□	No 1	Yes	2□ No
	f Vita ysicien: is certific director,	To Be	examiner?	26. Place of Death Other: 4 ☐ Nursing Hor	me 5 ☐ Residend	e 6 ∏Othe	er (Specify)
	on of ding Ph h. After thi funeral		1 Natural 5 Pending (Month, Day Year) Injury V	njury at 2 Work?	28d. Describe how			
	Division for Attending after death. Director: Atten	icati	Accident investigation Unknown Unknown M		Unknown	-4 1 8 6 1		D. (-1)
	Divisic	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown		28f. Location <i>(Stree City or Town, S</i> Unknown	et and Numbi State)	er or Hurai	Houte Number,
	tospite t hours tunerel	edical C	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the 2 ☑ Medical Examiner: On the basis of examination and/or investigation, in m and manner stated.	e time, date and place, a	and due to the caus	se(s) and ma and place, a	nner as sta and due to	ited. the cause(s)
_	To the Hos within 24 h To the Fur completely	Me		ense number		. Date signed		
			· auest.	OCME	Oc	ctober	6, 2	UU4
	10			Penn Street	, Baltimo	ore, Ma	aryla	nd 21201
	St Regis	tate trar	31. Date filed (Month, Day, Year) OCT 1 5 2004 32/Registrar's Signature					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ΑN	FND_ITFM_#26_PER_1 1. Decedent's Name (First, Middle, La:	State of Mary 7ERB-C836-10				Re	eg. No.2	04 3	2708
	Physicia	an						2. Date of Death Month	Dey	Year	Time of Death
1	/Medic	al	Brian Paul Bert 4e Fecility Neme (If not institution, give				4b. City, Town, or	October	13, 20		:00 PM
7	Examin	er	503 Maple View D				Bel			Harford	1
-	Funeral		5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	1		(State or Foreign
	Director		027-20-5628 Usuel Residence of Decedent	Ø M 2□ F	76 Yrs.	Months Days	Hours Min.	(Month, Day, July 19		Rhode	Island
	ryland how		10a. Stete 10b. County	10	c. City, Town or Lo	cation					nside City Limits
	Sa-fa	octo	Maryland Harford		Bel Air						☐ Yes 2 No
	with th	급	10e. Street end Number			10f. Zip Code		10	ng. Citizen of V		
	a 23	eral	503 Maple View I	Drive 12. Wes Decedent Ever	r in 11 C 12 1	21014		nosify Voc or No	USA	e - American Ir	dian
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at other.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give		Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		ck, White, etc.	
2-0	72 hor	ted	15. Decedent's Ed (Specify only highest gre	lucetion	16e Decer	lent's Usual Occup	petion	tina	16b. Kind of Bu	usiness/Industr	
21215-0020	d within Jiene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ysicist	during most of word)	King	U.S. G	Sovernm	⊃nt
	be filed d other event,	Be C	17. Fether's Neme (First, Middle, Last)			,	18. Mother's Nan	ne (First, Middle, M			
Maryland	ould b Ments arked	2	Romeo E. Bertra	and			Franc	es Cathe	rine Br	ogan	
Mar	izsh hand hand reum	İ	19a. Informant's Name/Relationship (7					rel Route Number,	-	- 0	(e)
	1 end Health em 27 ither tu	-	Evelyn A. Bertrar 20a. Method of Disposition		Ob. Place of Dispo	sition (Neme of		Bel Ai		21014 City or Town,	State
Baltimore,	Pages nent of I nt: If he iry or o		1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify		•	netory or other pla	1				
=	artme ortan Injur		21. Sonature of Funeral Service Licen		Hilltop :	Service (. Name and Addre	ss of Fecility_	10-15-04	Towso	n, Mar	yLand
ä	permit. Departr Importa		> 1000 MO(100	Do				ome, P.A.			2 21000
	V 100 C /		23a. Part1. Enter the cisease, or composhock, or heart failure. List only	cations that call sed the	ath. Do not ente	er the mode of dyir	ng, such as cardiac	ad, Abing or respiratory arre	gaon, M	App	roximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	e.	a St	omach				Ons	rval Between let and Death
	-	- l	resulting in dealiny	Due	to (or as a conseq	uence of):					
	uted d ansit	퉅		b.	to for as a conseq	ar and a D				1	
o,	an an irial-tr	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540	ic (or as a conseq	derice dij.				1	
68760,	ificete be executed g physician and as the burial-trensit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue	to (or as a consequ	uence of):					-
			L	d							
Вох	atten	cian									
P.O.	thet the deeth cert ed by the attendin deteched for use	by Physician/N	Part II. Other significant conditions co	entributing to deeth but no	ot resulting in the ur	iderlying cause giv	en in Part I.	23b. Did tob		tribute to the 3 ☐ Probably	csuse of death? 4 ☐ Unknown
ري ص	signed to	질						16116	s zezno	3 Probably	4 🗆 OHKHOWH
Records,	The law requires that the deeth cert ate has been signed by the attendin page 2 should be deteched for use	Completed	- A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A					24a. Was an perform		availabl	utopsy findings e prior to ion of cause i?
	The law ate hes page 2	E						1 ☐ Yes	s 200 No	1 ☐ Yes	2 No
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			20		th (Check only one)		
5	Physic this co	၉	1 Yes 25 No	Hospital: 1 Inpatient	2 ER/Outpatien		4 U Nursing H	ome 5 Resider			
	Ilng P	<u>ö</u>	27. Menner of Death 125 Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey Ye	ar) 28b. Time of Injury	28c. Injur Wor M 1	y et k? Yes 2 □ No	28d. Describe hov	w injury occurre	ed	
5	To the Hospital or Attanding Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - building, etc. (S	At home, farm, streepecify)		163 2 2 110	28f. Location (Stre City or Town,	eet and Numbe State)	er or Rurel Rou	ite Number,
	To the Hospital within 24 hours of To the Funeral Completely filled	edical C	29a. Certifier Certifying Phy (Check only one) Medical Exam	vsicisn: To the best of my iner: On the basis of exa and manner stated.	/ knowledge, death mination and/or inv	occurred et the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the cau	use(s) and mai te and place, e	nner es stated	cause(s)
	omple	Ž	29b. Signeture and title of certifier	and mainer stated.		29c. Licens				(Month, Dey,	
	- 5 - 0		M M	1)		71	8487		10/14	104	
		-	30. Name end address of person who c	ompleted cause of deeth	(Item 23e) (Type, I		1 /	UTE ZED	1-	1 1 10	7
	10T1		V''(U (MTH)	4 600 0	1+1 4	NOD QU	1195). SU	ult Leo	Will	4/K, 100	1 0111

B' HART, Elizabeth

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			Please			artment of Heal		•		gible.	
			1 - For Stata Registrar	Otato or wi		rtificate of Dea			. No.	n.	32700
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Death	154	Year	3. Time of Death
	/Medic	cal	Elizabeth P. Bit			4h Gib Tana	the of Books	October		2004	1:00 P M
	Examin	ier	4a. Facility Name (If not institution, give Greater Baltimore		Center	4b. City, Town, or Local Towson	tion of Death			nty of Death	
	Funeral		5. Social Security Number 6. 5		e (In yrs. last birthday)		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Y		imore 9. Birthi	place (State or Foreign ntry)
	Director		229-24-2119 Usual Residence of Decedent	I WI ZKYF	89 Yrs.			04-20-19	15		ŴV
	ryland how		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	he Ma	Director	MD Baltimo	re	Clifton	/East End					1 ☐ Yes 2 ☐ No
	with t		10e. Street and Number 1039 Lerew Way			10f. Zip Code 21205		10g		of What Cou	ntry?
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispani If Yes, specify Cuban, Me	c Origin? (Spec	cify Yes or No-	14. F	S.A. Race - Ameri	
36	s after	by Fu	1 ☐ Never Married	Armed Forces? 1 ☐ Yes 2X1 If Yes, Give	No.	37	acity:	ican, etc.)		Black, White, c <i>ity:</i> Whi	
9	filed within 72 hours after death with the Maryland Hygiene. tither than natural; or Rems 23a or 28a-f show ant, the Macilcal Extra ill art cust be in illied at		15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Occupation		16		Business/In	
21215-0036	ithin 7. 18. 18. "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Give	kind of work done during DO NOT use retired)	most of working	g			,
	ifed w Hygier ther th	Cor	unk 17. Father's Name (First, Middle, Last	unk	H	omemaker	Anthor's Name	(First, Middle, Mai	wn Ho		
au	d tal	To Be	Ben Belcher	,			ink	(First, Middle, Mai	uen sun	iairie)	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If itam 27 is marked other than "naturat, or itams 23a or 28a-f show or other traumatic event, the Modical Ext Inst ust be notified at	-	19a, Informant's Name/Relationship (19b. Maili	ng Address (Street and No	umber or Rural	Route Number, C	ity or To	vn, State, Zip	Code)
	l and dealth		Rev. Les Metcal	f/Pastor		Holmehurst				21228	
timore,	Pages 1 nent of P int: if ita iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State		esition (Name of matory or other place) Cemetery	10/16			n - City or To	
E E	permit. Page Department of Important: ff any injury or once.	1	21. Signature of Fundamental Signature	7		2. Name and Address of F				nore Funera	
Ba	Per Imp		1 6			1211 Chesaco					571,565,4 COF C
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	the death. Do not ent	er the mode of dying, such	h as cardiac or	respiratory arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hepl	7	neimont	9				Onset and Death
r	Examiner				a consequence of)						
	p it	Iner	Sequentially list conditions, if any, leading to immediate cause. End Unerlying Cause (Disease or injury	Due to (or as	a consequence of):						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of);					_	
/60	te be executed ysician and e burial-transit	cal		d.							
9	g 5.5	Physician/Medi	IF FEMALE:						1		
ROX	atter for u	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy				Date of delive Month	ery Day Year
oʻ.	0 0 0	nyslo	1 ☐ Yes 2. WNo 9 ☐ Unknown	9 Unknown	time of death 5	Other (specify)					
S,	as tha	by P	Part It Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause given in P	art I.	23e. Did tobac	co use co	ontribute to th	ne cause of death?
ord	w require been st	eted	Myocarolla	Marret	10n			1 Tes	2 🗆 No	3 Prob	ably 4 Unknown
Hecord	The taw cate has b page 2 s	Completed	ne moration	4				24a. Was an autopsy performed		b. Were auto prior to con death?	psy findings available mpletion of cause of
		Be Co	25. Was case referred to medical	Ne		26 P	Place of Death	1 ☐ Yes 2 ☐ Check onlone	No		200
<u> </u>	Physician: this certifice ral director, p	To B	examiner? 1 □ Yes 2 □ No	Hospital: 1 A patie	nt 2 ER/Outpatier	04		e 5 ☐ Residence	9 6 □ 0	ther (Specify	y)
DIVISION OF	ding P h. After t funera	lon:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	Year) 28b. Time of Injury	Work?		d. Describe how i	njury occ	urred	
<u> </u>	al or Attandi after death. I Diractor: A d in by the fu	ertification;	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of this	ury - At home, farm, str	M 1 Tes 2		f. Location (Stree	t and Nui	nber or Rura	i Route Number.
5	lospital or , thours after unaral Dire sly filled in E	Cert	4 Homicide	building, et	c. (Specify)			City or Town, S	tate)		
)	Hospital or Attanding Physician: 44 hours atter death. Funaral Director: After this certificately filled in by the funeral director,	Medical	(Check only 2 Medical Exar	niner: On the basis of	examination and/or in-	n occurred at the time, date vestigation, in my opinion,	e and place, an death occurred	d due to the cause I at the time, date	e(s) and i	manner as st	ated. the cause(s)
	To tha Hosp within 24 ho To the Funs completely fi	Med	29b. Signature and title of certifier	and manner sta	ited.	29c. License numb	per	29d.	Date sign	ned (Month,	Day, Year)
)	- > - 0		1500			0006	1886	16	//	4/0 9	<i>‡</i>
			1/ 0 1/1	completed cause of d	eath (Item 23a) (Type,		11 61	1	-/-(-)) []	21204
	Sta	te.	31. Date filed Month, Day, Year)	3. Registra	ar's Signature	- 67011	N.Clv	inles 5	I. I	a Itm	nove, MP
	Registr		OCT 1 5 200		. It Ages	de la company de					

		ľ	1 - For Amend Items Registrar	24a,25,26	Maryland 6,27,30	/ Depa per l <i>Cel</i>	rtment of I	lealth a	nd Mer /04dh	ntal Hyg	giene Reg. No.?	(3)	00710
	Dhusisi		1. Decedent's Name (First, Middle,	Last)					2.	Date of Dea	Fam. Co.	Voor	3. Time of Death
	Physici /Medic		Gregory		L.	Cı	cawley ,	Sr.		9	_		6:15p M
	Examin	er	4a. Facility Name (If not institution,	give street and numb	ber)		4b. City, Town, o	or Location of	of Death				L
			9 Bridgelake (. Age (In yrs. last	himb do . cl	If Under Char	svill	€ Hrs a	Data at Bird		Year 2004 County of Death Baltimore 9. Birthplace (State or Fore County) MD. 10d. Inside City Lim 1 Yes 2 en of What Country? A 4. Race - American Indian, Black, White, etc. Specify: Black d of Business/Industry Varies Sumame) Hendrick Town, State, Zip Code) 21239 ation - City or Town, State Calk, Md. Te, Md. 21202 The Ave. Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death ADD The Country Year But The Country Year A Unknown Year But The Country Year B	
	Funeral Director		213-84-0377	1 MM 2□F	_ , ,	Yrs.	Months Days	Hours	Min. 8.	Date of Birt (Month, Day			lace (State or Foreign ltry)
			Usual Residence of Decedent		43					2–26–	-01	L.	ιŲ.
	show		10a. State 10b. County		10c. City, T	own or Lo	cation					1	0d. Inside City Limits
	e Ma Sa-f s	cto	Md. Balti	more	C	ockey	vsville						1 X Yes 2 □ No
	with the Marylar a or 28a-f show be notified at	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	itry?
	s 238		9 Bridgelake Ci			10.1	21034				USA		
.=	ours after death wit iral', or items 23a c	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	Armed Ford		13. \	Vas Decedent of F Yes, specify Cub	dispanic Orig an, Mexican	gin? (Specify i, Puerto Ric	Yes or No- an, etc.)			
336	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 If Yes, Give Year or Dat	es:		∏Yes 2\XNo	Specify:			Speci	fy: B1	ack
21215-0036	72 hours "natural", idical Ex	ted	15. Decedent's	Education	1		lent's Usual Occup				16b. Kind of E		
218	thin 7 e. an "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	tor 5+)	life. L	kind of work done OO NOT use retire	d) mosi	or working				
2	be filed within 72 hotal Hygiene. dother than "natuevent, the Madical	Con	llth grade			Secu	rity						
and	be fill	Be	17. Father's Name (First, Middle, L								Maiden Suma	me)	
Maryland	nd 2 should be filed within 72 hours after death with the Maryland aith and Mental Hygiene. 27 is marked other than "natural", or tems 23a or 28a-f show r fraumatic event, the Medical Examinar must be notified at	ပို	George 19a, Informant's Name/Relationshi	W.	Crawl		a Address /Street		izabet				
Ma	d 2 th a		George W. Crawl		ther		Pentwoo						
<u> 5</u>	E SE SE		20a. Method of Disposition	c _f	20b. Place	e of Dispo	sition (Name of	1	Date		-		
9	Pages nent of I int: If its iry or of		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		ate	-	natory or other pla nel Cem.	· 1	9-21-0	4	Dundal	k. Md	
Baltimore,	permit. Pages 1 Department of the Important: If ite any injury or ot once.		21. Signature of Funeral Service L				. Name and Addre			_			
m	Pe Pe Pe		> Mlas	has w	ane	> i	March F.	H. Eas	st	1101	E. Nor	Ma. th Ave	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that can	used the death. [Do not ente	r the mode of dyin	ng, such as	cardiac or re	spiratory ar	rest,		Approximate Interval Between
	Pnysician	9	Immediate Cause (Final disease or condition	(0100	AKI	1 H+	AR.I	0	LIE	ISE		Onset and Death
	/Medical Examiner		resulting in death)	Due t (or	r as a consequen		1		-		40		0.14
2	Lammer	_	Sequentially list conditions,	b	THE	_	CLER	021	2				12 / EAN
~	lsit led	Examine	n any, teauting to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of	r as a consequen	ce or):							
0	xecul al-tra	xan	that initiated events resulting in death) Last	c. Due to (or	r as a consequen	ce of):						_	
11) 8	The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dicai E		4									
68	ificate g phy as the	ledic											
CX 8	death certifics attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnancy		Ectopic pregnancy	,					ry
0 B	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death		Other (specify)	y 			Me	onth	Day Year
P.O.	that the de led by the dedetached	Phy	9 Unknown	82									
() 0	ires tha signed I be det	by	Part II. Other significant condition	F. WJ 161		ig in the ur	iderlying cause giv	ren in Part I.					
500	w requir been si should	ompleted	CONCER	Elvalo			. 0	1. 2			es 2□No	3 [] Prob	abiy 4 Unknown
600	e law has b	nple	OB	4011VF	= (-1)	KW	DY D	JENJ	E	24a. Was a autop	sv	prior to con	osy findings available npletion of cause of
~ <u> </u>		O								perfor 1 ☐ Yes			2 No
TX X	Physician: The rithis certificate harral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (C				
5 to	F 를 들	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	oatient 2□ER Injury 28	Outpatien b. Time of	28c. Injur	7 1140			ence 6 □Oth ow injury occur)
on	th. : After s funer	tlor	1 Natural 5 ☐ Pending 2 Accident investiga	(Month,	Day Year)	Injury		k? Yes 2⊡N			, , , ,		
Division	Attendi ar death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 28e. Place o	f Injury - At home g, etc. (Specify)	, farm, stre	eet, factory, office		28f.			ber or Rura	Route Number,
Ö	s afte	Cert	4 _ Homode	Ballaling	д, в.с. (<i>Specily)</i>					City or Tow	n, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	<u></u>	(Check only 2 ☐ Medicel E	xeminer: On the bas	is of examination	dge, death and/or inv	occurred at the tir	ne, date and	d place, and h occurred a	due to the c	ause(s) and m	anner as sta	ated. the cause(s)
	thin 2 the other mplet	Medic	one) 29b. Signature and title of certifier	and manne	r stated.		29c. Licens						
	Z × Z		Day of the state o	1//	n.				60		nal.	-/-	anh I
	4		30. Name and address of person w	ho completed save	of death /line on	a) (Tues		372	80		07/1	5/2	.004
	-1		1				•	D1J	C+-	204	De1 = -))	1 220
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signature	,	/	DIVU	, ole	ZUO,	DATT CO.	, MU Z	1439
	Registr	ar	OCT 1 5 200	1 Bent	na B	1	oak						

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			1 - For State Registrar	State o	f Marylar	-	artment of F				iene	04	327	Miles in Land
	Physici		Decedent's Name (First, Middle, Marian Caughma:	,					1	Date of Dea Month October	Day	Year	3. Time of	
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu			4b. City, Town, o	r Location		ccoper		2004 nty of Death	2:45	P
			Gilchrist Cente					Towso:				imore		
	Funeral Director		215-40-1819	1 M 2 F	7. Age (In yrs.	62 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day)	, Year)	9. Births Cour Mary	place (State on htry) Land	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						Od. Inside C	ity Limite
	Maryl f sho	Ď	MD N/A			ltimore							1 ☐ Yes	1.
	r 28a	rec	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	of What Cou	ntry?	
	th with	a D	6721 Thruway				21222				United	Stat	es	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tien 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Madical Examiner must be nutified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	Ve/		Nas Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Ori an, Mexicar Specify:		fy Yes or No- can, etc.)	14. R B	lace - Americ	etc.	
ž	2 hou		15. Decedent's	Education			lent's Usual Occup				16b. Kind of	White Business/In		
21717	d within 7. giene. ar than "n . Ine Medi	Completed	(Specify only highest Elementary/Secondary (0-12) 8	grade completed) College (1-4or 5+)	(Give life. L Domes	kind of work done DO NOT use retired tic	during mos d)	st of working		Reside	ential	ŕ	
	oe file tal Hy d othe	Be C	17. Father's Name (First, Middle, La							First, Middle, I		ame)		
<u>Z</u>	ould I Meni	ဥ	Otis Maxwell Qu		na					lse Cau				
2	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationshi Betty Neubauer/			1	g Address <i>(Street</i> Fenwick				-		Code)	13
נֿע	Heall Heall tem 2		20a. Method of Disposition	315001	20b.	Place of Dispo	sition (Name of		Dat			n - City or To	own, State	
2	Pages ent of nt: If i		1 ☐ Burial 2 DiCremation 3 `4 ☐ Donation 5 ☐ Other (Spe	Removal from	State	-	natory`or other plac ke Cremat	1	Oc 20	t 15 04 I	Beltsv	ille,	MD	
	permit. Departm Importar any inju		21. Signature of Funeral Service Li		MOOS	286 22	Name and Addre Cremation 3717 Gree	ss of Facilii and	ty Funer	al Alte		ves imore	, MD	
	cate be executed / Medical Examiner the burial-transit the burial-transit	dical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last	a Due to b Due to c.		quence of):	ast cav	(Cel					Interval Bet Onset and I	Death
.O. BOX 001	The faw requires that the death certificate the has been signed by the attending phy; bage 2 should be detached for use as the	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 TVN o 9 Unknown	1 Live t	tcome of pregn pirth 2 ☐ Feta nant at time of c own	aldeath 3	Ectopic pregnancy Other (specify)	,				Date of delive		Year
, CD	quires than signed and be de	d by P	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	nderlying cause giv	en in Part I			acco use co es 2 □ No	entribute to that	1.	leath? Jnknown
	The lav ate has page 2	e Completed	25. Was case referred to medical					00.00	- Coult (No.	death?	psy findings and pletion of ca	available ause of
	To the Hospital or Attending Physician: The la within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date (Mon		ER/Outpatien 28b. Time of Injury	28c. Injun Wor	er: 4 🗌 Nu	ursing Home	Check only on 5 Reside	nce 6	other <i>(Specif</i>) urred	/) Hosp	ice
	To tha Hospital or Attending F within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer.	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place	of Injury - At h ing, etc. (Speci	ome, farm, stre	eet, factory, office		28f	Location (Sti City or Town		mber or Rura	l Route Num	ber.
	To tha Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical	29a. Certifier (Check only one) 2 Medical E	caminer: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date an pinion, dea	nd place, and occurred	d due to the ca at the time, da	use(s) and rate and place	manner as st e, and due to	ated. the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier	7	-		29c. Licens				_	ned (Month,		4.8
	Λ		Milane	-mo			D5	85C	3	C	CTOP	ser 1	3 200	7
	5		30. Name and address of person w		se of death (Iter		Print)					harles		et
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 5 2004	Sene	legistrar's Signa	gre A	ports			1	OWSUII	, riu.	21204	

			For State Registrar		State of I	Maryla		artmer <i>rtificat</i>			nd M	ental H	ygien Reg. N	2.111	err ³ rq	327	12
	Physic	ian	Decedent's Name (F	First, Middle, L	*			1				2. Date of D	eath		V	3. Time of	f Death
	/Medi		John	۷			salis-	ta		_		Detob	Di ex		Year Zoo4	042	26 AM
	Examir	ner	4a. Facility Name (If no	nt institution, g	ive street and number	er)	,	4b. City,	Town, or	Location of I	Death		4	c. County	of Death		
			5. Social Security Num	's Hop	Kines He	spria	4	Bax	fin	lore	CI	fy					
	Funeral Director		195-22-48 Usual Residence of De	58	Sex 7., 1∑M 2□F	Age (in yrs	i. last birthday)	If Under Months	Days	If Under 24 Hours	Min.	8. Date of B (Month, D Jun 16	irth Pay, Year 19	28	9. Birthpl Count Penr	ace (State o try) ISYLVA	or Foreign nia
	land			Ob. County		10c. C	ity, Town or Lo	cation							10	d. Inside Ci	ity Limite
	death with tha Maryland rms 23a or 28a-f show	ector	Maryland	Carr	oll				Ta	neyto	wn					1 ☐ Yes	
	th with t	al Dir	3111 Benja		rive			10f. Zip		21787			10g. C	itizen of V	Vhat Count	try?	
	ems erm	ner	11. Marital Status		12. Was Decede Armed Force	nt Ever in l	J.S. 13.	Was Deced	dent of His	spanic Origin	? (Spe	cify Yes or N Rican, etc.)	0-		e - America		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dep riment of Heatth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show any njury or other traumatic avent, the Medical Exertine rivest be notified at ange.	by Funeral Director	1 Never Married 3 Widowed 4		1 Tes 2 If Yes, Give	XNo		1⊡Yes		Specify:	-иөпо н	Rican, etc.)		Specify	k, White, e	_{hite}	
2-0	72 ho	sted	15 (Specify	. Decedent's I	Education rade completed)		16a. Dece	dent's Usua	al Occupa	tion	4 . 4		16b. F	(ind of Bu	siness/Ind	ustry	
Maryland 21215-0036	i within jiene.	Completed	Elementary/Seconda		College (1-4c	or 5+)	life.	ring of wo DO NOT us Teacl		uring most of	t workin	ng		Sch	nool	•	
br	ba filed tal Hygi d other avent, II	BeC	17. Father's Name (Firs	st, Middle, Las	st)					18. Mother's	Name	(First, Middle	, Maider	Sumam	θ)		
ylaı	should b nd Ments markad umatic a	To	Stephen									izack					
Mai	d 2 sho th and ty is ma traums		19a. Informant's Name		<i>(Type, Print)</i> lista, wif	-						Route Numb				Code)	
	Heal Heal tem 2		20a. Method of Disposi		II.SCa, WII		Place of Dispo			DETAG	-	aneyto			∴ 1/8/ City or Tow	m State	
Ω	Pages nent of int: If it		1 ☐ Burial 2 🛣 C 1 ☐ Donation 5 ☐		Removal from Stat	te	cemetery, crer arroll	natory or o	ther place	· 1					-		
Baltimore,	permit. F Dep rtmr Importar any njur		21. Signature of Thera			0 723				S LU, of Facility		/2004			stead	, MD	
ä	Dep Import any r		Xtu	4121	1071	IN	6					line F Hamp:				7/i	
	-		23a. Part 1. Enter the d shock, or heart fa	lisease, or con	nplications that caus	ed the dea	th. Do not ent	er the mod	e of dying	, such as car	rdiac or	respiratory a	rrest,	ω, 1 <u>π</u>		Approximate Interval Between	9
Ш	Physician		Immediate Cause (Fina disease or condition	al	a Card	_	scula		. 1	apse						Onset and D	eath
	/Medical Examiner		resulting in death)	•	Due to (or a	is a consec			h.			.)				7 1100	CO
		9.	Sequentially list conditi	ions,	b. Massi		howe	li	sche	mica	av	12 N	ecno	115	-	TH	777
	utad d ansit	Examiner	Sequentially list conditi if any, leading to immer cause. Enter Underlyin Cause (Disease or inju- that initiated events	ig ry	540.0 (0.2	.0 2 0011000	quorico oi).										
0,	cate be executad bhysician and the burial-transit	Еха	resulting in death) Last	- 1	c Due to (or a	s a consec	quence of):								-		
8760,	ate be nysicii he bu	dical		•	d												
99 x	ertifica ling ph e as t	0 1	IF FEMALE:														
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pre in the past 12 mor 1 Yes 2 No 9 Unknown	nths?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fete	el déath 3 🗆	Ectopic pre Other (spe						23d. Date Mon	of delivery th D		ear
S,	es tha igned b	by P	Part II. Dther significan	it conditions	contributing to death	but not res	sulting in the ur	iderlying ca	iuse given	in Part I.		23e. Did t	obacco u	ise contri	bute to the	cause of de	ath?
Records,	v require baan si should b	ted									_	10	Yes 2	No :	3 Probab	oly 4 □Ur	nknown
ec	has by	Completed										24a. Was	an	24b. W	ere autops	y findings av	vailable
		Cor										perfo	rmed? 2 No	de	eath?	No No	436 01
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred t examiner?	o medical	Hospital:	_			_		Death (Check only c	one)				
of	Phys this ral dir	<u>L</u>	1 Yes 2 No 27. Manner of Death		28a. Date of In		ER/Outpatient			4 LI Nursin		e 5 ☐ Resid					
O	ding th. After funer	tion	1 Natural 5	Pending investigation	(Month, D	ay Year)	28b. Time of Injury	M 28	lc. Injury a Work?	it os 2 □ No	28	d. Describe I	now injur	y occurre	d		
Division	el or Attending safter death. I Diractor: After d in by the fune	fica		Could not be	28e. Place of Ir	njury - At h	ome, farm, stre			5 2 140	28	f. Location (S	Street an	d Number	or Bural B	Route Numbe	O.F.
-	To the Hospitel or Atten within 24 hours after deat To the Funerel Diractor: completely filled in by the	Certification:	4 Homicide		building, 6	atc. (Specii	y) 					City or Tov	vn, State,)			e/,
	ne Hospitel (n 24 hours al ne Funerel D bletely filled i	edical	29a. Certifier 1 (Check only 2 one)	Certifying Pl Medical Exa	hysician: To the bes miner: On the basis and manners	oi examina	wledge, death tion and/or inv	occurred a estigation,	t the time in my opir	, date and planion, death or	ace, an	d due to the d at the time,	cause(s) date and	and mani place, ar	ner as state id due to th	ed. ie cause(s)	
	To the within 2 To the complete	ž	29b. Signature and (it)	of certifier N	1000				License r						(Month, Da		
)) ta	wel I		1.17.		K	es	- 01	00		Oct	ober	12	, 200	+
			30. Name and address of	1 4	al - 1.	.)	1 0	rint)	1000	2	110.	nere,	LIN	71	287	-916	6
3	Stat	te	31. Date filed (Month, D			rar's Signa	iture	(E >	1.661	1241	I'LI V	vere/	200	- (
	Registra	ar	CCT	1 5 200	14 Maria	1	Local Contract	1									

			For	State of M	faryland / D	•			and Me	ental Hyg	iene		40
			Registrar 1. Decedent's Name (First, Middle, La	ct)		eniiic	ate of L	Jeath		Re 2. Date of Deat	eg. No.		3. Time of Death
	Physici		Norma	10	CCG					Month De Teber	Day	Year	Z:45PM
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. C	city, Town, or	Location o	f Death	CICUTA	_	County of Death	Crist
	Exciniii		Riverview Nursing	Home		Е	ssex				1	Baltimor	·e
	. Funeral		5. Social Security Number 6. S	6ex 7. A	ige (In yrs. last birth	day) If Un	der 1 Year	If Under a	24 Hrs. Min.	B. Date of Birth (Month, Day,			place (State or Foreign
	Director		217-18-8521 Usual Residence of Decedent		80 Y	rs.				1/1/192	5	4	yland
	ow ow		10a. State 10b. County		10c. City, Town	or Location					•		10d. Inside City Limits
	Man a-1 sh	tor	MD Baltim	ore	Dunda	1k							1 ☐ Yes 2 🙀 No
	or 28.	Director	10e. Street and Number			10f.	Zip Code			10	0g. Citiz	zen of What Cou	ntry?
	ath w	lal	1925 Guy Way				21222					U.S.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or flems 23s or 28s-f show avant, I'm Medical Eraint actimative rodified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 2X If Yes, Give Year or Dates	s?] No		ecedent of Hi specify Cuba s 212 No	spanic Orion, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		4. Race - Americ Black, White, Specify: Whit	etc.
9	2 hou		15. Decedent's E (Specify only highest gra	ducation	16a. I	ecedent's U	Isual Occupa	ation	a fi sua ekies		16b. Kin	nd of Business/In	dustry
21215-0036	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4o		life. DO NO	work done of Tuse retired)	OF WORKING			_	
12	e filed within al Hygiene. I other than vant, I've Me		5 17. Father's Name (First, Middle, Last)	Hom	<u>emake</u>	r	18 Mothe	r's Name	First, Middle, M		n Home	
and	ould be f Mental t arked of atic ava	o Be	Calvin Baublitz	,						osley	vialuoi i	Surramey	
Maryland	SP E E	F	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Addr	ress (Street a				City or	Town, State, Zip	Code)
₹.	and 2 salth a n 27 is er trai		Marie Serio/Daugh	ter	962	3 Nin	th Ave	nue B	altin	nore, M	ary1	and 212	34
ore	of He of He if itan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from Stat	20b. Place of I cemetery	Disposition (crematory	Name of or other place	9)	Da	te 2	20c. Loc	cation - City or To	own, State
Baltimore,	t. Pag tment rtant: njury (* 4 □ Donation 5 □ Other (Specif	ý)	Parkw				10/18	3/04	Ba1t	imore,	Maryland
Bal	permit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or other trau		21. Signature of Funeral Service Licer	\supset		6415		r Roa	d Bai	ltimore	, Ma	Funera	1 Home Inc. 21206
	Pnysician /Medical Examiner	ılner	an Part . Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leasn to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or a	is a consequence of	30	Alex	S C	Training of	as C	est,	7	Approximate Interval Between Onset and Death
, 68760,	death certificate be executed e attending physician and nd for use as the burial-transit	Medical Examine	that initiated events resulting in death) Last	d	s a consequence of):							
.O. Box	that the death certifics ed by the attending ph detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Fetal death at time of death	3 □Ectopi 5 □ Other	c pregnancy (specify)				23	3d. Date of delive Month	ery Day Year
ords, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions of	ontribution to death	but not resulting in	he underlyir	ng cause give	en in Part I.		23e. Did tob 1 ☐ Ye		se contribute to the	he cause of death?
al Records	The law ate has b page 2 s	Completed							_	24a. Was ar autopsy perform 1 Yes	ned? No	prior to condeath?	psy findings available mpletion of cause of
Vital		o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpa	tient 2□ER/Out	entiont 2	DOA Othe	14157-1007-		Check only one		F10# (C)	
of	g Physer this eral di	-	27. Manner of eath	28a. Date of In (Month, D	jury 28b. Ti	ne of	28c. Injuny	at		d. Describe ho		Other (Specif	y)
ion	Attanding F r death. ector: After by the funer.	atlo	Natural 5 Pending investigatio	n	/ay / 6 a/ /	ury M	Work	.r ∕es 2□h	No				
Division	tal or Attands safter death	Certification:	3 Suicide 6 Could not be determined	289. Place of I	njury - At home, farr etc. <i>(Specify)</i>	n, street, fac	tory, office		28	If, Location (Str City or Town		Number or Rura	l Route Number,
~	To the Hospital or Atlanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one)	nysician: To the bes niner: On the basis and manner	of examination and	or investigat	tion, in my op	oinion, deat		d at the time, da	ate and p	place, and due to	the cause(s)
V.	To with	Σ	29b. Signature and title of certifier	lil		(29c. License	3 3	7/	09	De	signed (Month,	2004
	6		CINDA TUS	completed cause of	10/0	ype, Print)	lee	Kor	d	Belle	lu i	4021	015
	Sta Registr		31. Date filed (Month, Day, Year) CCT 1 5 2004	100	trar's Signature	3	9						

			for State Registrar	State of	Marylar		artment rtificate				lental Hy	giene Reg. No.	200	1	327	7 1
	Physici	an	1. Decedent's Name (First, Middle Alberta		11		D			-	2. Date of Dea Month	ith Day		'eer	3. Time of	
	/Medi	cal		Casse			Davi			15	10	11		004	11:a	1 M
	Examir	ner	4a. Fecility Name (If not institution) 1300 E. Lan			Apt. 8	4b. City, To		alti		•	40.	County of			
	Euporal	7	5. Social Security Number			last birthday)	If Under 1			24 Hrs.		1	N		ce (State o	or Foreign
5.	Funeral Director		214-38-0084	1□ M 20 F	66	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day 6-28-	, Year) -38		Country	Md.	n i Grengii
	D		Usuel Residence of Decedent								0 20	50			Ma.	
	show	L	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							100	I. Inside C	•
	8a-f	cto	Md.	NA		Baltin	nore								1X Yes	2 No
	ith th	Director	10e. Street and Number				10f. Zip C	ode				l 0g. Citiz	en of Wh	at Countr	/?	
	ath w		1300 E. Lanval					2121					IISA			
	tems tems	Funeral	11. Marital Status	12, Was Decede Armed Force	s?	.S. 13.	Was Deceder f Yes, specify	nt of His y Cuban	panic Ori	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	1	4. Hace - Black,	American White, et	n Indian, c.	
36	or .	by F	1 ☐ Never Married 2 ☐ Marri 3 🖫 Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Date			1 ☐ Yes 2	No Ž	Specify:				Specify:	Blac	k	
21215-0036	d within 72 hours after death with the Maryland jiene. rithen "natural", or Items 23e or 28e-f show I're Medical Examinar must be notified at	edt	15. Decedent		· · · · · · · · · · · · · · · · · · ·	16a Dece	dent's Usual	Occupat	ion					ness/Indu		
15	n ne	Completed	(Specify only highes	t grade completed)	<i></i>	(Give	kind of work DO NOT use	done du	iring most	t of worki	ng	100. 141	o or busin	1622/11/00	Siry	
212	d within plene. r than "	Eo	Elementary/Secondary (0-12) 12th grade	College (1-4	or 5+)	Self	-Emplo	yee				Truc	king	Co.		
D	il Hygi other	Be C	17. Father's Name (First, Middle, I	Last) L Yrs		,	-	_		r's Name	(First, Middle,					
lar	ould be Mental Marked o	To B	Woodrow		Cass	ell			Aı	nna			Mil	6 9		
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (S	Street a	nd Numbe	r or Rura	/ Route Numbe	r, City or		9.0	ode)	
Σ	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Melvienia Baylo	r Dau	ahter	4806	Trues	dal	o Am		altimor	N	a	2120		
ore			20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	of er place) I	- 7 6	altimor	Loc	allion - Ci	y or Town	, State	
Ĕ	Pages ment of ant: If its ary or o		1 Purial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Lo	oudon P	ark]	10-16	5-04	Balt	imor	e, Mo	đ.	
Baltimore,	permit. Page Department of Important: If any injury or stage.		21. Signature of Funeral Service L	icensee / 2		22	. Name and	Address	of Facility	у	Bal	Ltim	ore	, Md	. 2	1202
-	805 8	/L 13	France	- Kofe	~~>	M	arch	F.F	1. E	ast					Ave	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that causonly one cause on each	sed the deat	h. Do not ent	er the mode of	of dying,	such as	cardiac o	r respiratory arr	est,		l Ir	pproximate	ween
	Physician		Immediate Cause (Final disease or condition	- Lu	na	Canc	er	m.	e+	25+	atic			5	nset and [JTHS
	/Medical Examiner		resulting in death)	Due to (or	as a conseq		+								1-01-	11.
25	LXaiiiiiei	_	Sequentially list conditions,	b												
	be sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):										
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to for	as a conseq	uence of):										
8760	death certificate be executed e attending physician and id for use as the burial-transit															
687	ficate phys s the	edicai		0					,							
Box (leath certific attending pi	Physiclan/Me	IF FEMALE: 23b. Wes decedent pregnant	23c. If yes, outcor	ne of pregna	incy						22	d. Date o	f delivery		
	death a atte	clai	in the past 12 months?	1☐Live birth			lEctopic preg l Other (spec						Month	Da	ıy Y	'ear
0	that the deby the detached	hys	9 Unknown	9□ Unknowr	1											
٣,		by P	Part II. Other significant condition	ns contributing to deat	but not res	ulting in the ur	nderlying cau	se given	in Part I.		23e. Did tol	oacco us	e contribu	te to the	cause of de	eath?
of Vital Records	w requires been sign should be										1 🖄 Y	s 2 🗆	No 3[Probab	ly 4 □U	inknown
တ္ထ	> 0 5	Completed									24a. Was a	n	24b. Wei	e autopsy	findings a	available
æ	9 - 9	E O									autops	ned?	dea	th?	letion of ca	tuse of
<u>ra</u>	sician: Th certificate rector. pag	0	25. Was case referred to medical						26 Place	of Death	(Check only on			Yes 2[] No	
>	S S F	ToB	examiner? 1 ☐ Yes 2 🗷 No	Hospital:	atient 2	ER/Outpatien	3 DOA	Other			ne Reside		Other (Specify)		
0	ding Phi h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of in (Month, in	njury Day Year)	28b. Time of	28c	. Injury a Work?	at		8d. Describe ho					
Ö	Attending r death. actor: After by the fune.	atic	2 Accident investig	ation	,,,,,	injury	М		s 2 🗆 N	10						
Division	I or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	nod 286. Place of	Injury - At ho	ome, farm, stre	et, factory, o	office		2	8f. Location (St City or Town	reet and	Number o	or Rural R	out e Numb	ber,
	itel or rel D led ir															
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical	(Check only 2 Medicel E	Physician: To the be xaminer: On the basis	of examina	wledge, death tion and/or inv	occurred at estigation, in	the time my opir	, date and	d place, a h occurre	nd due to the ca	use(s) a	nd manne lace, and	er as state	d. e cause(s)	
	the the mplei	Med	29b. Signature and title of certifier	and manner	stated.			icense i								
	F 3 F 8	NT.	203. Signature and the or certifier	Da PH	7510	CLAN			359	0				fonth, Daj		1
	1		J. J. X.											~	-10	2004
	1		30. Name and address of person v	no completed cause of ROOM	oeath (Item		21-	7.4	NO	MH	1D BRO	ADL	MAY			
	Sta	te	31. Date filed Atanth, Day, Year)		strar's Signa	turg	have	. , , , ,	-,	4-0-	- 60		-2			
	Registr		06/13/200	4 Denie	a 1	9 1	man of	2								

Clarence 04-6461		anı	ner, Jr.		e Type or Pri					•			
AKG			1 - For Unp State Registrar	end Item	State of M 23a,27,28	a f per m	ertificate	10-7. of 1	Death	gieritai ny	Reg. N		32715
	Physici	an	1. Decedent's Name							2. Date of D Month		ay Year	3. Time of Death
	/Medio		Clarence	e 	R.		Danner	Ĺ	Jr.	Month Octol	oer	6, 2004	6:30 PM
	Examir	er			rive street and number)				Location of Deatl	h	4	c. County of Dea	ith
0			3415 Fal:				Balt					N/A	
19/1/09	Funeral		5. Social Security N 215-42-6		Sex 7. Ag	e (In yrs. last birtho 60 Yrs	Months	Year Days	If Under 24 Hrs. Hours Min.	(Month, D	av, Yea	r) C	rthplace (State or Foreign ountry)
3	Director		Usual Residence of		A		s.			July 9	9,19	144	1D.
	land ow		10a. State	10b. County	-	10c. City, Town o	r Location						10d. Inside City Limits
	Mary f sh	ō	MD.	N/	A	Balt	imore						Yes 2 No
	the	Director	10e. Street and Nur	mber			10f. Zip C	ode			10g. C	Citizen of What C	ountry?
	3a or		3415 Fal.	ls Road			21	1211	1			USA	,
	deetl ms 2	Funerai	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Was Deceder	nt of H	ispanic Origin? (S	pecify Yes or N	0-	14. Race - Am	
9	after or Ite		1 Never Marr	ied 2 Married	Armed Forces?		1 Tes, specify	_	ın, Mexican, Puert	o Rican, etc.)		Black, Whi	_{te, etc.} Vhite
93	ours rail,	d by	3 ☐ Widowed	4X Divorced	If Yes, Give Year or Dates:		TILL Tes 22	7 1 I/IO	Specify:			Specify: V	MITCE
2-(72 h netu	Completed	(Spec	15. Decedent's cify only highest g	Education grade completed)	16a, D	ecedent's Usual Give kind of work	Occupa done d	ation during most of wor d)	rking	16b.	Kind of Business	/Industry
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2	lled v lygie her t		12 years		as)	Se	curity (Juai		- /Fi Mid-H		tate Pol	lice
anc anc	tal H	Be	Clarence		•				18. Mother's Nan		e, Maide	an Sumame)	
<u>₹</u>	d Me nark natic	ဥ	19a. Informant's Na			106.84	Antiform Address //	21-1-1	Thelma		0''	T 011	7.0
_ ⊠	d2 s th an 7 is r treur			·		10	-		and Numberor Ru K Trail,		-		ZIP Code)
رة	1 an Healt em 2		Kimberly 20a. Method of Disp		daughtei	20b. Place of D	isposition (Name	of				Location - City or	Town State
Jor	ages nt of :: # it		1 🗆 Burial 2	Gremation 3	☐Removal from State	cemetery,	crematory or other	er plac		Date Cober			
돌	it. P. Introductions or tend	. 0	21. Sign ture of Fu	5 Other (Spec	• •	Dayview		_		, 2004			City, MD.
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or Items 23a or 28e-f show any injury or other treumatic event, it a Meulical Example, in the India of 2006.	, 1	21. Signature 011 d	moral Service Lic	V		Connell	ſÿÏ	uneral F	Iome Of	Dun	dalk,P.A	١.
			23a, Part1, Enter ti	he disease, or co	implications that caused	the death. Do not			ers Point			dalk, MD.	21222 Approximate
			shock, or hea Immediate Cause	irt failure. List on	ly one cause on each li	ne.		,	g,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a	c intoxic							
	Examiner				Due to (of as	a consequence of):	•						
		er	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	b. Due to (or as	a consequence of):	;						
	be executed sicien and burial-transit	Examine	cause. Enter Unde Cause (Disease or that initiated events	injury									
ó.	be executed icien and burial-transil	Exa	resulting in death)		Due to (or as	a consequence of):							
760,	le be /sicie e bur				d								
687	tifica ig ph as th	ed		-									
Вох	leath certificate b attending physic I for use as the b	Physician/Medical	IF FEMALE: 23b. Was deceden		23c. If yes, outcome		3 □Ectopic preg	nanov				23d. Date of de	livery
Θ.	ne deat the att hed for	sicis	in the past 12 1 Pyes 2	□No	4☐Pregnant at		5 Other (spec					Month	Day Year
P.O.	that the d ed by the detached	h	9 🗌 Unknown	4 B C							_		
s,	w requires tha been signed I should be det	by F	Part II. Other signif	icant conditions	contributing to death b	ut not resulting in th	e underlying cau	ise give	en in Part I.				the cause of death?
ord	equir sen si ould	ted								1 🗆	Yes :	2 □ No 3 □ P	robably 4 Unknown
e C	ne law r has be ge 2 sh	pie								24a. Was		24b. Were a	utopsy findings available completion of cause of
<u>m</u>	The ate h page	Completed								M yes	ormed?	death?	_
/ita	Phyeicien: The Is rthis certificate har ral director, page 2	Be (25. Was case refer examiner?	red to medical					26. Place of Dea				
£	hyei his c	မ	1 X Y es 2 □			ent 2 ER/Outpa		Othe	er: 4 🗆 Nursing H				city) at scene
u u	ding Ph h. After th funeral	lon:	27. Manner of Deat 1 □Natural	5 Pending	Found Found	y Yea <i>r)</i> 28b. Tim Inju	e of 28c	. Injury Work		28d. Describe		ury occurred	
Division of Vital Records,	Mtendii death. ctor: A y the fu	Certification:	2 ☐ Accident 3 ☐ Suicide	investigati	10-6-04	Unkne			Yes 2 X No	Unknow			
Ξ	of or Attend after death Director: ,	ıtil	4 Homicide	determine	building, et	ury - At home, farm c. (Specify)	, street, factory, o	office		City or To	Street a wn, Sta	te) $3415~\mathrm{F}$	ural Boute Number, alls Rd.
J	pitel ours a erel l		29a. Certifier	1 Contituing	Hone Physicien: To the best	of multipoularies, of		Ma = 41		Baltimo			
	24 hc 24 hc Fun stely	edical	(Check only one)	2 Medicel Ex	eminer: On the basis of and manner sta	f examination and/o	er investigation, in	my op	oinion, death occu	red at the time,	date ar	s) and manner as nd place, and due	s stated. To the cause(s)
	To the Hospitel or Attending Phyeicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Me		title of certifier	A		29c. L	License	e number		29d. D	ate signed (Mont	h, Day, Year)
	⊢s⊢ŏ) //	1 /n K	OIAAD			0.0	C.M.E.			ober 8,	
			30. Name and addr	ress of person wh	o completed cause of d	leath (Item 23a) (Tu	ne Print)						
		1 8	TIARO	N Loe	te (MI)	(non zoa) (1y		enn.	Street,	Baltimo	ore.	Marylar	nd 21201
	Sta	te	31. Date filed (Mon	ith, Day, Year)	32. Registr	ar's Signature						4	
	Registr	ar	90	T 1 5 200	14 16	K de	acts s						

1.			1 - Stete Unpend Ite	State o em 23a-d&2	of Marylai 27 per 1	nd / Depa ne G836	artment of 10-28-0 rtificate of	Health Deat	and M	ental Hy	giene Reg. No.	001	
	٥		1. Decedent's Name (First, Midd					_		2. Date of De	eath	. 644	3. Time of Death
	Physici		Michael Lawren	ao Davia						Month Octob	Day		2.20 3 M
	/Medic Examin		4a. Facility Name (If not institutio		ımber)		4b. City, Town,	or Locatio	n of Death	CCLOO		2004 County of Deat	2:30 A
	LAGIIII		Upper Chesapea	ke Medica	1 Cente	יירנ	Bel Ai	r			H=	rford	
0	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs		If Under 1 Year	If Und	er 24 Hrs.	8. Date of Bi	rth		hplace (State or Foreign
3	Director		144-42-8915	1 M 2□F		53 Yrs.	Months Days	Hours		(Month, D.		Co	ountry)
5-	D		Usual Residence of Decedent							Mar 28	, 195	o I New	Jersey
	ylan		10a. State 10b. County	1	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	Ma-f s	to	MD Harfo	ord	Jo	рра							1 □Yes 2X No
	ith the Marylan or 28a-f show e notified at	Director	10e. Street and Number			<u> </u>	10f. Zip Code				10g. Citiz	zen of What Co	ountry?
	238 o		1013 Plaza Circ	710			21085				IIn i +	ed Stat	-00
	deati ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U		Was Decedent of	Hispanic (Origin? (Spe	cify Yes or No	T-	4. Race - Ame	nican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene. It ams 23 or 28a-f show tiam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant. It a Medical Examinat must be notified at	by Fur	1 Never Married 2 Mar 3 Widowed 4 Divorced	16 V C	No No		If Yes, specify Cut 1☐ Yes 2 No			Rican, etc.)		Black, White Specify:	e, etc.
Ş	"natural",	pa		nt's Education		16a Dece	dent's Usual Occu	nation			16h Kin	Blac nd of Business/	
5	in 72 Bri r Bodic	Completed	(Specify only highe	est grade completed		(Give	kind of work done DO NOT use retire	durina m	ost of working	ng			
5	with ene. thar	E C	Elementary/Secondary (0-12)	College ((1-4or 5+)		Clerk	,			ттqи	or Reta	arrer
9	filed Hygi thar	Ö	17. Father's Name (First, Middle,	Last)		1 BCOCK	CIEIK	18. Mo	ther's Name	(First, Middle	. Maiden :	Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. is marked othar than sumatic avant, the M	00	Booker Drinka	rd						e Holm		,	
\geq	houl d Me mark mati	2	19a, Informant's Name/Relations			19h Mailir	ng Address (Stree					Toum State 7	Zin Codo)
_ E	d 2 s th an 7 is				- 1								up code)
	ss 1 and 2 of Health itsm 27 i		Ms. Darlene Dr. 20a. Method of Disposition	Inkard/SIS			imball Cosition (Name of	ourt		a, MD		cation - City or	Town State
کّ	ages or o		1 ☐ Burial 2 SCremation			cemetery, crer	natory or other pla	ice)		ct 15			
ij	t. Partumentant		`4 □ Donation *5 □ Other (5		Ch	-	ke Crema			004	Belt	sville,	MD
Baltimore,	permit. Pages 'Department of H Important: If its any injury or of		21. Signature of Funeral Service	LICENSEE	M00980	0 0	2. Name and Addr Cremation 3717 Gree	n and	Funei				MD
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that	caused the dea							Itimore	Approximate Interval Between
,8760,	Physician / Medical Examiner building and building the prize transit the prize transit.	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, factoring to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	ceritone (or as a conse- lble Rup (crass a conse- tor as a conse- aic Alco	quence of): oture of quence of): Liver quence of):	f Retrop	erito	oneal '	Varix			
9			IF FEMALE:	220 If yes ou	itcome of pregn	ana.							
P.O. Box	Attanding Physician: The law requires that the death certificach. r death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	birth 2 ☐ Fet nant at time of	al death 3	Ectopic pregnand Other (specify)	;y			2:	3d. Date of deli Month	very Day Year
	w requires tha been signed I should be det		Part II. Other significant conditi	ons contributing to c	death but not re	sulting in the u	nderlying cause gr	ven in Par	t I.		obacco us Yes 2 🗆		the cause of death?
Division of Vital Records,	ding Physician: The law requ h. After this certificate has been funeral director, page 2 shoul	Completed								24a. Was auto perfo			topsy findings available completion of cause of
/ite	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		_				ce of Death	(Check only	опе)		
)f	Physi this c al dire	2	1X Yes 2 No] ER/Outpatien	I J DOA					□Other (Spec	cify)
ū	ding P. I. After t	ino ::	27. Manner of Death 1 ₩ Natural 5 Pendii	28a. Date na <i>(Mor</i>	of Injury oth, Day Year)	28b. Time of Injury	28c. inju Wo	ry at rk?	2	8d. Describe	how injury	occurred	
<u>S</u> .	death. death. ctor: A y the fu	cati	2 Accident investi	igation]Yes 2[□ No				
Divi	af or Att	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 28e. Place build	e of Injury - At h ling, etc. <i>(Speci</i>	iome, farm, str fy)	eet, factory, office		2	8f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or Attanowithin 24 hours after death To the Funaral Diractor: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifyii 2 Medical	ng Physician: To the Exeminer: On the b and man	e best of my kn pasis of examination stated.	owledge, death ation and/or inv	n occurred at the tr vestigation, in my	me, date opinion, d	and place, a eath occurre	nd due to the d at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within To the comp	ĕ	29b. Signature and title of certifie	ər			29c. Licens	se numbe	г		29d. Date	signed (Month	, Day, Year)
) Carol	Hall		ud		OCMI	E		Octob	per, 14	, 2004
			30. Name and address of person	WANTII	Penn S	treet,	Print) Baltimor	e, M	arylan	d_2120	1		
:	Sta Registr		31. Date filed (Month, Day, Year, OCT 1 5 2	/ 2002-1	Registrar's Sign	ature		,	<u>_</u>		-		
			- L T O 6	-	744	1	-						

			For State	State of Maryla	•			Mental Hyg	giene	2001	
			Registrar		Cei	tificate o	t Death		leg. No.	<u> 2004</u>	32717
п	Physici	an	1. Decedent's Name (First, Middle, La	o ide	o Gal	a		2. Date of Dea	Day		3. Time of Death
	/Medio	- 10	4a. Fecility Name (If not institution, giv	e street and number)	ega	4b. City, Town	, or Location of Deat		-	County of Dee	th
	L X d I I I I	ei	2103 ARNEN	DR.		Fal	ISTON		H	tartor	ed
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	(last birthday)	If Under 1 Yea Months Day			Year)	9. Bir	thplace (Stete or Foreign
	Director		Usual Residence of Decedent		0 / 113.			8-11-	1.1	HA	GENTINA
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	the Marylar 28a-f show	ctor	MD Harton	d	Fa	10101	<u> </u>				1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number	NO		10f. Zip Code	11/17		10g. Citiz	zen of What Co	buntry? L
	ns 23	eral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No-	1	14. Race - Ame	
9	or Iter	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		f Yes, specify Ci	A			Black, Whit	e, etc.
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show Ita Medical Exactions trial Les collified at	d by	3 Widowed 4 □ Divorced	Year or Dates:				entinian		W	nite.
	in 72 nat	Completed	15. Decedent's E (Specify only highest gra	ide completed)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of wo	rking	160. Kir	nd of Business	rindustry
2121	filed with Hygiene. Wher the	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	hor	remai	KER		a	t hon	Ce.
	should be filed within 72 hours after death w of Mental Hyglene. marked other than "natural", or Items 23a matic event, tra Modical Exambratinal.	Be	17. Father's Name (First, Middle, Last	2001:			18. Mother's Na	me (First, Middle,	Meiden	Sumame)	
Maryland	should be nd Mental marked c	L C	CMMe LA CO	RSUINI	10h Mailie	a Addrona /Stea	et and Number or Ri	15ta	1 C	ZRS1	Zin Code)
Ma	2 g a s		19a. Informant's Namer Helationship (olo dano	21/12	April S	FALL DO F	allston	, chy ch	70 -2/	047
re,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tri anges.		20a. Mp(hod of Disposition		Place of Dispo	sition (Name of natory or other p	nlace)	Date	20c. Lo	cation - City or	Town, State
imo	Pages ment of I ant: If Its ury or o		1 Ø Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special	Removal from State	rdens o	offa. thi	CON . 10-	15-04	Ros	edale	mas
Baltimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee (A)	22	2. Name and Add	dress of Facility FO				
	00380		23a Part 1 Enter the disease proof	plications that caused the de	ath. Do not ent	ANS FULL		PEL-BEL c or respiratory ar		3080	Approximate
	Obveision		23a. Part1. Enter the disease, or conshock, or heart faillire. List only immediate Cause (Final		-	1==0	- 1	C-00 %			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse			1312				1400
- T	Examiner		Sequentially list conditions,	b							
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or many)	Due to (or as a conse	equence or):						
Ć.	ate be executed physicien and the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
8760	ite be iysicie ne bur	cal		d							
9	entifica ling ph e as tl	Med	IF FEMALE:	GGo If was subsempled association							
Вох	leath certifica attending ph I for use as th	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death 3	Ectopic pregnal			2	3d. Date of de Month	livery Day Year
0	t the d	hysk	1 Yes 2 No 9 Unknown	9□ Unknown							
s, P	The law requires that the death certific tite has been signed by the attending p tage 2 should be detached for use as		Part II. Other significant conditions	1	sulting in the u		given in Part I.			1	the cause of death?
ord	w requir been si should	ted	13 (3) The 18	Ers DIS	- Se Se			1 🗆 Y		N/2-2	robably 4 Unknown
Vital Records,	The law cate has b page 2 st	Completed by						24a. Was a autop perfor	sv	24b. Were at prior to death?	utopsy findings available completion of cause of
al		e Co	25. Was case referred to medical				ne Place et Do	1 ☐ Yes ath (Check only or	2 No	1 🗆 Yes	2 PNo
\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA	Other: 4 Nursing P			□Other (Spe	cify)
n of	ng Ph ter thi	T:uc	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe h			•
Sio	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be	n			☐Yes 2☐No	20f Leasting (C	*****	d Mumbo	Control Control Number
Division	lor At after o Direct in by	Certification:	4 Homicide determined		nome, tarm, str	eet, factory, office	08	City or Tow			ural Route Number,
_	hours nerel y filled	alC		nysician: To the best of my ki							
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	fedical	one)	miner: On the basis of examination and manner stated.	nation and/or in						
	With To	×	29b. Signature and title of certifier	rai m			973 7 26			signed (Mont	
	1-		30. Name and address of person who		am 23a) (Tuno						ber 2004
	V		S. Rag eros.	completed cause of death (its	S. Atc	220000	Ros #	ion B.	-10	Mr. H	00 21044
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		land.	1				

DHMH 17 Rev 1/2001

			4 17.	partment of Health and Ment ertificate of Death	tal Hygiene
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Lenora N. DeGasperis	N	Date of Death Month Day Year tober 13 2004 4 4 M
	Examir		4a. Facility Name (If not institution, give street and number) 5414 McCormick Ave	4b. City, Town, or Location of Death Raspeburg	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 235-42-3712 Usual Residence of Decedent 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) 77 Yrs.	Months Days Hours Min. (A	Date of Birth Month, Day, Year) 8-17-1927 9. Birthplace (State or Foreign Country) WV
	Maryland	tor	10a. State 10b. County 10c. City, Town or L MD Baltimore Raspebu:		10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	ter death with the Marylan Itams 23a or 28a-f show Inctriust by notified at	al Director	10e. Street and Number 5414 McCormick Ave	10f. Zip Code 21206	10g. Citizen of What Country? U.S.A.
980	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show dical Examinar roust by notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 X No Specify:	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	within ene. than "	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) r Clerk Typist	16b. Kind of Business/Industry Bayview Hospital
yland	should be fited and Mental Hygie marked other Imatic evant, Imatic evant	To Be (17. Father's Name (First, Middle, Last) Michael Epifano	Anna Rosa R	
, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: if itam 27 is marked any injury or other traumatic elege.		Armando Herman DeGasperis/Husb. 5414	ing Address (Street and Number or Rural Rou McCormick Ave Raspeb	burg MD 21206
timore	Pages 1 tment of H tant: If ita ijury or ott		4 Donation 5 Other (Specify) Oaklawn	Cemetery 10-16-0	
Ba	permil Depar Impor any in		Shape Uta 1	211 Chesaco Ave Balt	
8760,	hysician and Examine the burial-transit	al Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cayse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	SUPAA PUCKERA	piratory arcest, Approximate Interval Between Onset and Death
O. Box 687	death certifi e attending ed for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	Se 050	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Record	The taw ate has b page 2 sl	Completed			24a. Was an autopsy findings available prior to completion of cause of death? Yes 2500 1 Yes 2 No
of	dis y	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of D ath 28a. Date of Injury 28b. Time o		eck only one) 5 AResidence 6 ⊡Other (Specify) Describe how injury occurred
Division	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification:	1 CNatural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	M 1 Yes 2 No reet, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, Sity or Town, State)
>	ha Hospital or n 24 hours afte ha Funaral Dir. pletely filled in I	edical	29a. Certifier (Check on) one) 1 Certifying Physician: To the bast of my knowledge, deatl 2 Medical Examiner: On the bast of examination and/or in and granner stated.	h occurred at the time, date and place, and du vestigation, in my opinion, death occurred at the	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
)	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier LUY (29c. License number 3 8 0 3 3	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) and Ave BE	ACTIMO13 de) 21824
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 5 2004 32 Registrar's Signature	34	

			For 1 State	State of Ma	aryland / Depa	artment of F			0001	
			1 - State Registrar	1	Ce	runcate or	Deam	1	g. No.	32/19
	Physici		1. Decedent's Name (First, Middle, La.	•	EKNAT	EL		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv			,	r Location of Death	1	4c. County of Deat	
	Exami		Franklin Square	Hospital		Roseda	1e		Baltimo	~e
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9 Birt	hplace (State or Foreign
	Director		215-22-9887	□ M 2X□ F 7	8 Yrs.	Month's Days	Hours Min.	Jan. 31,	1926 Mary	1and
	p ,		Usual Residence of Decedent		10- 01- 7					
	anylan show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1 X Yes 2 ☐ No
	8a-f	cto	Maryland		Balti					
	or 2	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at	Funeral Director	5808 Plumer Av			2120			U.S.A.	
	er de	une	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	s aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1 □ Yes 2 1 No	Specify:		Specify: Whi	ite
21215-0036	72 hours natural', lical Exa	pa p	15. Decedent's E		16a Dece	dent's Usual Occup	ation	1	6b. Kind of Business/	
5	in 72 n "na	Completed	(Specify only highest gra	ade completed)	(Give	kind of work done	during most of wor	king	ob. Killo of business	moustry
12	withir ene. than	E C	Elementary/Secondary (0-12)	College (1-4or !	5+)	emaker	•		Own Home	
9	e filed withi al Hygiene. I other than vent, the M		17. Father's Name (First, Middle, Last,)	TOM	JIII CHE CI	18. Mother's Nan	ne (First, Middle, M		
Maryland	s 1 and 2 should be filed within 72 hc I Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical	To Be	Arnold	Holste			Margar	et	Getz	,
<u> </u>	2 should be and Menta Is marked aumatic ev	1	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street			City or Town, State, 2	
S	and 2 sealth ar n 27 is		William Deknatel	Hushand	1	B Plumer		Baltimor		
ē,	s 1 and 3 t Health item 27 other tr		20a. Method of Disposition	., naspana	20b. Place of Dispo	sition (Name of			Oc. Location - City or	
no	Pages nent of I int: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Moreland	matory or other place		12/2004	Baltimore	MD
Baltimore,	7 5 4 5	1	21. Signature of Funeral Service Licer		and the second second second second	2. Name and Addre		12/2004	baltimore	MD
Ba	permit. Departn Importa any inju		16/	3		Miller-	Dippel Fu	uneral Ho	me, Inc.	21206
			23a. Part1. Enter the disease, or con	pications that causer	t the death. Do not ent			ad Balti		Approximate
			shock, or heart failure. Listerily	one cause on each li	ne.					Interval Between Onset and Death
e)	Physician /Medical		disease or condition resulting in death)		ICREAT	10 C	ANCER	<u> </u>		2 months
п	Examiner			Due to (or as	a consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):					
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
<u>,</u>	execin and in and ial-tra	Exa	resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	ate be executed hysician and the burial-transit	dical	(d						
89		edic								
ŏ	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7-			23d. Date of deli	very
ğ	death a atte d for	icia	in the past 12 months?	4☐Pregnant at]Ectopic pregnancy] Other <i>(specify)</i>	·		Month	Day Year
0	that lhe de led by the a detached	hys	9 🗆 Unknown	9∐ Unknown						
S, P	The law requires that the tee has been signed by the bage 2 should be detache	by P	Part II. Dther significant conditions of	ontributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	<i>n</i> require been sig should b							1 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Record	s bec	Completed						24a. Was an	24b. Were au	topsy findings available
Re	The lav	mo						autopsy perform	ed? death?	completion of cause of
Vital		a	25. Was case referred to medical				26 Place of Dea	th (Check only one		2 140
>	S S	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatier	ıt 3□ DOA Oth	00		ce 6 □Other (Spec	cify)
o			27. Manner of Death	28a. Date of Inju				28d. Describe how		
Division	or Attending I ifter death. Director: After in by the funer	atio	1 Natural 5 Pending 2 Accident investigation		y Year) Injury		Yes 2 □ No			
Vis	or Attencatter death	ific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Inj	ury - At home, farm, str c. (Specify)	eet, factory, office			et and Number or Ru	ral Route Number,
Ö	al or A s after if Direction by	Certification:	4 Homede	building, et	c. (Specily)			City or Town,	Siate/	
)	hour hour nera y fille		29a. Certifier 1 Certifying Pr	ysicien: To the best	of my knowledge, deat	n occurred at the tin	ne, date and place	, and due to the cau	se(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Exar	and manner st						
	Vithi To t	Σ	29b. Signature and title of certifier	1 ^	0	29c. Licens	e number	290	1. Date signed (Monti	Day, Year)
			1	in	· . .	0.	4534	0	TOper,	8,2004
•	3		30. Name and address of person who	completed cause of c	leath (Item 23a) (Type,	Print)	ola HO	II R at	1500-	000 212
	/		M70 MIN (M.D	·) 8114	sand p	per Ci	rce ++ 2	in, Sal	THORE	2004 MD 212
	Sta		31. Date filed (Month, Day, Year)			120				
	Registi	ar	007 1 5 200	The second	A ARRAN	Carlo Sale				

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H		, ,	iene _{Bg. No.} 0 0 1	32720
	Physici		Decedent's Name (First, Middle, Last, Samuel		3.	Edward	s	2. Date of Deat Month OCTOBER	Day Ye.	ar 3:05 PM
	/Medic Examin		4a. Facility Name (If not institution, give Union Mem. Hos			4b. City, Town, or Ba	Location of Deat	h	4c. County of D	Peath
	Funeral Director		217-30-4283	M 2 F	e (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 9. 35	Birthplace (State or Foreign Country) Md.
	Maryland -! show	tor	Usual Residence of Decedent 10a. State 10b. County Md . NA		10c. City, Town or Lo					10d. Inside City Limits 1X1Yes 2 ☐ No
	with the a or 28a	Director	10e. Street and Number			10f. Zip Code	218	10	0g. Citizen of What	Country?
36	hours after death with the Maryland lural', or Items 23a or 28a-f show at Examinar in ust by motified at	by Funeral	532 E. 23rd St 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	Vo Or	Was Decedent of H. If Yes, specify Cuba 1 ☐ Yes 🎉 No		Specify Yes or No- to Rican, etc.)	14. Race - A	American Indian, Vhite, etc. Black
Maryland 21215-0036	within 72 ene. than "nai	Completed t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 9th grade	cation	(Give iife.	dent's Usual Occupion kind of work done of DO NOT use retired	during most of wo f)	rking	16b. Kind of Busine	Baltimore
land 2	uld be filed fental Hygir rked other lic avant, L	To Be Co	17. Father's Name (First, Middle, Last) Clifton	Edv	wards, Sr		18. Mother's Na	me (First, Middle, M		34242
Baltimore, Mary	Pages 1 and 2 should be nent of Health and Mental int: If item 27 la marked or y or other traumatic av	-	19a. Informant's Name/Relationship (T) Josephine Edwa 20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	rds Willemoval from State	ife 53	matory or other plac	rd St.,	Baltim	ore, Md 20c. Location - City	. 21218
Baltii	permit. Pages Department of I Important: If its any injury or or		21. Signature of Funeral Service Licens		1	2. Name and Address March F	ss of Facility		Baltim	ore, Md2120.
8760,	And in the private personnel of the private pr	dical Examiner	23a. Part1. Enter the disease, or comp. shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or a) Du	a consequence of): a consequence of):	ter the mode of dyin	g, such as cardia	c or respiratory arre	sst,	Approximate Interval Between Onset and Death 30 mmutes
.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
<u>α</u>	quires that I n signed by uld be deta	by	Part II. Other significant conditions co	ntributing to death bi	ut not resulting in the u	inderlying cause give	en in Part I.		/	e to the cause of death?] Probably 4 Unknown
Vital Records,		Completed	Unusual interstit	nal promin	nontis			24a. Was ar autops perforn 1 Yes 2	y prior	a autopsy findings available to completion of cause of 1? Yes 2 No
	Phyaician: 7 r this certificar ral director, p	o Be	25. Was case referred to medical examiner?	lospital:	ent 2 ☐ ER/Outpatie	nt 3 DOA Oth	or	ath (Check only one Home 5 - Reside		Program (
ion of	nding Physath. r: After this e funeral di	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day		f 28c. Injun Worl	y at	28d. Describe ho		респу)
Division	tal or Atte s after dea al Directo ed in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, st c. (Specify)	reet, lactory, office		281. Location (Sti City or Town		r Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medicai ((Check only 2 Medical Exami		ol my knowledge, deat f examination and/or in ated.	vestigation, in my o	pinion, death occi	urred at the time, da	ate and place, and	due to the cause(s)
	or To with	H	29b. Signature and title of certifier	-5 (MD		243894	16-E10 C		7, 2004
	5		30. Name and address of person who c FLORELLO SVEN-ERI	K QUIAN	leath (Item 23a) (Type,	Print) On Memoria	al Hospita	Baltimore	MD 212	ty Pkwy.
	Sta Regist		31. Date filed (OCT 1 5 200)	32. Registra	ar's Signature	Spark	,			

62	3		Please i		ryland / De	partment of I	Health and N	•	•	ble.	0000	
	Physici	ian	Registrar 1 Decedent's Name (First Middle Last	illiam Per	-	Certificate of	Death	2. Date of Dea	th	Xear	3. Time of Death	
	/Medi Examir	cal	4a. Fecility Name (If not institution, give 2124 Lincoln Aven				or Location of Death	2. Date of Death October 13, 200	of Oeath	3:50 P		
	Funeral Director		Social Security Number 6. Sec. Sec. 1		(In yrs. last birtho	ay) If Under 1 Year Months Oavs	If Under 24 Hrs.	(Month, Day	Year)	9. Birthp	place (State or Forei intry) ryland	
	show	ž	Usual Residence of Oecedent 10a. State 10b. County		10c. City, Town o	r Location					l Od. Inside City Limit	
	or 28a-f	Funeral Director	Maryland B 10e. Street and Number	altimore		10f. Zip Code	Sparrow		0g. Citizen of V	What Cour		
	ath w	rai	2124 Lincoln Av						Unit	ed S	tates	
	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If tiere 27 is marked other than "netural", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinating must be notified at once.	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Endemed Forces? 1		13. Was Decedent of lif Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No- Pican, etc.)	Blac	ck, White,	etc.	
	eture cal E	per	15. Decedent's Edu	cation	16a. De	ecedent's Usual Occu	pation		16b. Kind of Bu		ite dustry	
	d within 73 giena. Ir than "no	Completed	(Specify only highest grade Elementary/Secondary (0-12) 11 Years	e completed) College (1-4or 5+) (G	ive <i>kind of work d</i> one ie. <i>DO NOT u</i> se retire Constructio	during most of work ad)	king			uction	
	at tile of he vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I	Maiden Sumam	10)	*	
	uld b Ments rked rtic e	2	Lawrence Elmore				Mar	y Ann Bo	emme1			
3 2 2	and land lis me	1 3	19a. Informant's Name/Relationship (T)	· · · · · · · · · · · · · · · · · · ·								
	and and ealth			Daughter		009 Delmar						
	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition 1									
	permit. Departimport any inj		21. Signature of Fareral Service Licens	Fm/ll/		7922 Wise	Ave. Dur	ndalk, Ma	aryland	, Inc		
	Medical /Reciped e parial-Itansit	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to make the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c.			ovaswim	R PIS	EASE		Interval Between Onset and Death	
	Ine law requires that the death certificate be ette has been signed by the attending physiciar bage 2 should be detached for use as the burit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. 23c. If yes, outcome o 1 □ Live birth 2	Fetal death	3 □Ectopic pregnanc	y				ery Day Year	
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me of death	5 ☐ Other (specify) _					,	
	w requires that it is basen signed by should be detailed	b	Part II. Other significant conditions co.	ntributing to death but	not resulting in th	e underlying cause gr	ven in Part I.				ref.	
	ne law req a has baar age 2 shou	Completed						autops perform	y ned? d	rior to cor leath?	psy findings available appletion of cause of	
	certiticata rector, pag	ပိ	25. Was case referred to medical				26 Place of Deat			Yes	2 □ No	
	ysici s cer direct	0 0	examiner?	Hospital: 1 Impatien	t 2 ☐ ER/Outpa	tient 3 DOA Ott				ar (Specifi	at scene	
	Attending Physician: It death. ector: After this certition by the funeral director.	ation: T	27. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Tim	e of 28c. Inju						
	ospitel or Attendous after death hours after death unerel Director: It tilled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.		street, factory, office				er or Rura	l Route Number,	
	I 4 II 0	Medicai (29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exami	sicien: To the best of ner: On the basis of e and manner state	examination and/o	eath occurred at the ti r investigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	tuse(s) and mai ate and place, a	nner as st	ated. the cause(s)	
	vithin 2 To the complete	Σ	29b. Signature and title of certifier			29c. Licens	O.C.M.E.					
		L 2	30. Name and address of person who co	ompleted cause of dea			reet, Bal	Ltimore,	Maryla	nd 21	1201	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	4						

State Registrar

OCT 1 5 2004

& Sports

			1 - For State Registrar	State of Ma	arylan		artmeni <i>tificate</i>			and M	7	giene Reg. No	nal		272	2
	Physici /Medio		1. Decedent's Name (First, Middle, Last Mary Margaret Est	e11							2. Date of De Month	Da	,200	ear 24	3. Time of Dear	h M
	Examir	er	4a. Facility Name (If not institution, give Millenium Nursin						Location o			4c	County of I.	Death Ward		
	Funeral		Social Security Number 6. Se		90 (In yrs. I	ast birthday) Yrs.	If Under Months		If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	v. Year)	9.	Birthplac	e (State or For	
	Director		234-03-1867 Usual Residence of Decedent								Jul. 16), 1	914		sylvani	
	Marylar f ahow	ō	10a. State 10b. County MD Baltin	moro	10c. City	, Town or Lo		Ltimo	2.76.0					10d.	Inside City Lin 1 ☐ Yes 🏋	
	or 28a-	Irect	10e. Street and Number	more			10f. Zip		51.6			10g. Cit	tizen of Wha	t Country	?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Itams 23a or 28a-f ahow any injury or other traumatic event, it. Medical Evair fact must be notified at once.	y Funerai Director	5147 Westland B1 11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 \(\subseteq Yes \) 2 \(\subsete N \) If Yes, Give			Was Deced f Yes, spec			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		ited S 14. Race - A Black, V Specify:	American White, etc	Indian,	
8	2 hours	ted by	3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Edi	Year or Dates:		16a. Deced	lent's Usua	I Occupa	ation			16b. K	ind of Busin			
Maryland 21215-0036	rithin 72 ne. I Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	life. L	kind of wor DO NOT us	e retired,)							
d 21	filad w Hygier sther th		8 17. Father's Name (First, Middle, Last)			Silk	Scre	een N			ring (First, Middle,		stingh Sumame)	ouse		
/lan	Mental Mental srked c	To Be	Joseph Straka						Ma	ry H	abzians	ky				
Mar	d 2 sho th and 7 Is mu traum		19a. Informant's Name/Relationship (T	,							I Route Numbe				ode)	
	of Heali item 2	1	Loran Estell, Jr 20a. Method of Disposition 1 Burial 2 Cremation 3 🔀		20b. P	lace of Dispo emetery cren t Oak	sition (Nan	ne of			altimor Date		ocation - City		, State	
Baltimore,	tment tent: H	1	`4 Donation 5 □ Other (Specify,		Las	Ce	meter	У	10		-2004	Moı	ganto	wn, I	WV	
Ba	permit Depar Impor eny in	(21. Signatul of Funeral Secretary	TON	1/8/						rose Fu Rd., A					
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	De,	n. Oo not ent	er the mode	e of dying	g, such as					Ap	oproximate terval Between nset and Death	
	Examiner		Sequentially list conditions,	Due to (or as a	a consequ	defice of).										
8760,	death certificate be exacutad e attending physician and of for use as the burial-transit	ai Examiner	if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury	cDue to (or as a												
9	tificate ig phys as the	ledic		d												
O. Box	that the death certifica ed by the attending ph detached for use as ti	Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	Ectopic pro		_				23d. Date of Month	f delivery Da	y Year	
rds, P.	law raquires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	entributing to death bu	ut not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t		\/		cause of death?	
Vital Records	The la ate has page 2	Completed									24a. Was autor perfo 1 \(\text{Yes} \)		prior deat	to compl	findings availa etion of cause	ible of
	Physicien: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatien	t 3 🗆 DQ	Othe			n <i>(Check only o</i>	/	€ □Othor /	Canaiful		
ion of	ding After fune	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y	28b. Time of Injury		8c. Injury Work	at	2	28d. Describe I			<i>Зреспу)</i>		
Division	or At after of Direct in by	Certiflo	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc			eet, factory	, office			28f. Location (3 City or Tov	Street an vn, State	nd Number o	r Rural R	oute Number,	
	a Hospital 24 hours a Eunerel I etely filled	edical	29a. Certifier (Check only one) (Check only one)	sician: To the best of iner: On the basis of and manner sta	examinal	wledge, death tion and/or inv	occurred a vestigation,	at the tim in my or	ie, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) date and) and manne d place, and	or as state due to the	d. e cause(s)	
)	To the within 2. To the I complete	Me	29b. Signature and title of pertifler	1/2	1	us	290	License	number 2 7	76		29d. Da	te signed (M	fonth, Day	200 4	/
	3		30. Name and address of person who o	11 770		23a) (Typa.	Print)	Poi	u.	Las	0 0	re la	t u	0	2/22.	P
	Sta Regist		31. Date fill (Vent) 1 23 72004	32. Registra			Loan	2			1					

		•	For State Registrar	State of	Marylan		artment rtificate				ental Hyg	iene eg. No. (101	0000
P	Physici	an	Decedent's Name (First, Middle, Ruby		ris			ieze			2. Date of Deat Month October	h Day	2004	3. Time of Death 8:00 P M
	/Medic Examin	100	4a. Facility Name (If not institution,				4b. City, T				october		unty of Death	
	LAGIIIII		Riverview Nursin	ng Home				Ess	sex				Baltim	ore
	Funeral Director		5. Social Security Number 219-50-5231	6. Sex 1 □ M 25 TF	7. Age (In yrs. 8		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, February	Year) 4,191	Col	nplace (State or Foreign untry) V •
	w w		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	n the Maryland r 28e-f show	lor	MD. Balti	more		Dundal								1 □ Yes 2 No
	death with the Maryland ms 23e or 28e-f show crust be nutified at	Director	10e. Street and Number				10f. Zip	Code 2122	2		1	0g. Citizer USA	of What Co	untry?
396	be filed within 72 hours after death with tal Hygiene. ad other then "neturel", or Items 23e or event, the Medical Examinar rust be	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Vidowed 4 Divorced	Armed For	2 ∏ №	1		ent of His	spanic Ori	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White pecify: Wh	, etc.
Maryland 21215-0036	within 72 hours after ene. then "neturel", or ite he Medical Examina	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed)	-4or 5+)	(Give life.	dent's Usual kind of work DO NOT us	k done di e retired)	tion uring mos	t of workin	ng		of Business/I	ndustry
121	e fifed within al Hygiene. I other then ' vent, the Me		9 years 17. Father's Name (First, Middle, L	asti		Hous	ewife		18. Mothe	er's Name	(First, Middle, M		Home	
/land	should be and Mental I marked o	To Be	Benjamin Henness	•							Henness			
Man	es 1 and 2 should b of Health and Ment: I item 27 is marked r other treumatic e		19a. Informant's Name/Relationsh Sheila Klinedins		hter	1	-				Route Number	City or To	own, State, Z	ip Code)
Baltimore,	Pages 1 are not of Hearint: If item		20a. Method of Disposition 1 Surial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from S	State 20b. P	lace of Dispo emetery, crer air Me	sition (Nam natory or ot	e of her place	9)	Octob	ate		ion - City or 1	
Balti	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service L	icensee	Der C	onnel.	Address	s of Facilit unera	al Ho	me Of D Road, D	unda]	k,P.A.		
	Physician		23a. Part1. Enter the disease, o shock, or heart failure.	complications that conly one cause on e	aused the death		er the mode	of dying	, such as	cardiac o				Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a conseq or as a conseq or as a conseq	uence of):								
P.O. Box 68	The law requires that the death certificate tee has been signed by the attending phy.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mô 9 □ Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3[Ectopic pre					230	l. Date of deli Month	very Day Year
ds, P	uires that signed b d be deta		Part II. Other significent conditio	ns contributing to de	eath but not res	ulting in the u	nderlying ca	iuse give	n in Part I.			acco use		the cause of death?
Vital Records,		Completed	Chronic	which	f ful	ND.VA	han	Λ,			24a. Was a autops perform 1 Yes 2	n 2 y ned?	4b. Were aut prior to c death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
Vita	Physician: The rithis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	r	/	(Check only on	-		
of	iling Phys n. After this funeral di	tlon: To	1 ☐ Yes 2 1 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of		ER/Outpatier 28b. Time of Injury		Bc. Injury Work	_ 4 _ NU	2	ne 5 Reside 8d. Describe ho			ify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, str	reet, factory,	, office		2	28f. Location (St. City or Town	reet and N , State)	lumber or Ru	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the Examiner: On the ba and mann	best of my kno asis of examina ner stated.	wledge, death tion and/or in	h occurred a vestigation,	at the time in my op	e, date an inion, dea	d place, a	and due to the ca	use(s) an ate and pla	d manner as ace, and due	stated. to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	M-P-			29c.	License	number 38	-75			igned (Month	
	3		30. Name and address of person w	who completed caus		23a) (Type,	Print) BAS	TE	RN	Bi	VD-	N	(p -	2004.
Ţ	Sta Registr		31. Date filed from Aay 5 e2	104	egistrar's Signa	ture	Lon	KN						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13 2004 **Physician** 0302 October Fenton Stella /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Nov. 16, 1921 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🔽 F Washington DC 82 Director 579-12-2414 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Example of minest by routile of at 1 ☐ Yes 2X No Director West River Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20778 4304 Rousbys Run Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. XXYes 2 □ No If Yes, Give Year or Dates: 1942–45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify: Specify δ 3XWidowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 11 Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Feurtch Charles Straining ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4304 Rousbys Run, West River, MD 20778 it of Health if item 27 i Margaret E. Passerini (Dtr) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) ō 10-16-2004 Baltimore, MD Department (Important: If any injury or Metro Crematory * 4 □ Donation 5 □ Other (Specify) 21. Signature of Foneral Service Licenses 22 Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac Arrhy Homia. 3 minutes disease or condition resulting in death) /Medical **Examiner** Cardiovalular disease Atherosclenotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 🗹 No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown Pseudomembranous colitis 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? throm busis vein autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 2 1 No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medicai Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) OCT 1 5 2004

Deale

C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

marci

Chrusch ten

29b. Signature and title of certifier



Road

29c. License number

Deale

50653

GYAN.C.

29d. Date signed (Month, Dev. Year)

SURANA

m.D.

10-13-2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #1 &4a PER PHY CO26tilled to 500 can Reg. No. EDWARD JUNIOUS FOWLKES 2. Date of Death 3. Time of Death **Physician** 45AM -04 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**7**M 2□ F Months Davs Director 10c. City, Town or Location Od. Inside City Limits 10a. State 10b. County or than "naturel", or Itema 23a or 28e-f show the Medical Exerting or must be notified at 1 es 2 No Director 10f. Zip Code 10g. Citizen of What Country? by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use patired) College (1-4or 5+) and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame Name (First, Middle, Last) 1 and 2 should be Health and Mental or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Nu permit. Pages 1 and 2.:
Department of Health at Important: If Item 27 Is any injury or other trau Baltimore, 20c. Location - City or Town, State Nethod of Disposition

Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner heim Sequentially list conditions, if any leading to lead to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ p9 3 Probably 4 Unknown 2 No 1 ☐ Yes Completed page 2 should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 No certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certifici completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical CertIfication: To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 7004

State Registrar

OCT 1 5 2004

MAC

32 Registrar's Signature

who completed cause of death (Item 23a) (Type,

31. Date filed (Morth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 14, 2004 5:20P WILLIAM MUIR FRANCIS, SR. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore County Towson 1556 Doxbury Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 11X M 2□ F Months Director 212-40-7497 69 Dec 15, 1934 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 ☐ Yes 2 ☐ No the Medical Exercities result by notified Director or 28a-f Maryland Baltimore County Towson 10e. Street and Number 10g. Citizen of What Country? with Items 23a 1556 Doxbury Road 21286 USA Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 4+ Credit Manager Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other treumetic event 2008. 36 2 Robert Naudain Francis, Sr. Christine Muir 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1556 Dox ury Road, Towson, Maryland 21286 of Disposition (Name of Date 20c. Location - City or Town, State (Wife) Helen L. Francis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 10/18/2004 Pikesville, Maryland 21. Signature Wurer Trivice Lichese Amartin D. Lawson Name and Address of Facility auso Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately an experimental such as a cardiac or respiratory arrest,

Approximately an experimental such as a cardiac or respiratory arrest,

Approximately a cardiac or respiratory arrest, metastatic Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav ō in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No the Division of Vital Records, P.O. 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 🕽 Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 1 Tes 5 esidence 6 Other (Specify) this 28d. A scribe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? . Manner of Cear 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 3 🖺 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) Ichand 16 30. Name and address of person who completed cause of death (Kerr 23a) (Type, Print) Richard Huslig, 7505 Osler Drive, Towson, Maryland 21204 M.D 31. Date filed (Month, Day, Year) State OCT 1 5 2004 Registrar

Amend Item 25,27,281ate of Manyland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 10 13 ames Gilliam 2004 11:15a /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Genesis N.H. Longgreen Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Months Hours 1⊠M 2□ F Vrs 225-42-7638 Director 70 Va Usuel Residence of Decedent be filed within 72 hours efter death with tha Marylend 10a. Stete 10b. County 10c. City, Town or Location r items 23s or 28s-f show sher must be notified at 10d. Inside City Limits 1X Yes 2 No Director Md. NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1414 N. Ellwood Ave. 21213 Funerai USA Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0020 traumatic event, the Medical Exam 1 ☐ Yes 2 X No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☑ Divorced Vear or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Bethlehem Steel 10th grade 17. Father's Neme (First, Middle, Last) parmit. Peges 1 end 2 should be fil.
Department of Haalih and Mantal Hy,
Important: If Item 27 Is merked other any injury or other traument 18. Mother's Name (First, Middle, Maiden Surname) Marshall Gilliam Sally Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Gilliam 1317 Glenmont Rd., Baltimore, Md. Daughter 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Diamond Grove Ch. Cem. 10-17-04 Skippers, Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 ada and March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last end Due to (or as a consequence of) ivision of Vital Records, P.O. Box 68760, attending physician for use es the hirial 1 abe Due to (or as a consequence of): CHI 346 DIO tobecco use contribute to the cause of death? is certificate has been signed by the a director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Linknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 0 1 🗆 Yes 2 1 Ne 1 ☐ Yes 2 ☐ Table To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Yes 2 N Director: After this fillad in by the funerel 27. Manner of Death 28a. Date of Injury unk | 28b. Time of unk | 28c. Injury at Work? 28d. Describe how injury occurred unk edicai Certification: Natural 5 Pending investigation death. 2 **X**No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number unk City or Town, State) unk 4 Homicide within 24 hours aftar To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14-04 00 60539 30. Name and eddress of person who co eted cause of death (Item 23e) (Type, Print) 308, Ballmone, M) 21201 tleade a N 5 2004 31. Date filed Registrar's Signature State Registrar

	Amend Item 8 per 1 State of Ma 1 - State Registrar		artment of Health a rtificate of Death		ene a. No.2 A. A. J.	0.7700
Physician /Medical	1. Decedent's Name (First, Middle, Last) Kathleen Gascoy	ne		2. Date of Death Month	Day Year	3. Time of Death
Examiner Funeral		e (In yrs. last birthday)	4b. City, Town, or Location of Baltimore If Under 1 Year If Under 2 Months Days Hours		4c. County of Death N/A 9. Birth	place (State or Foreign
Director	© 64-58-7356 1 M 2 √ F Usual Residence of Decedent 10a. State 10b. County	52 Yrs.		18711756	NOA Mic	ntry) chigan 10d. Inside City Limits
with the Marylis is or 286-f sho	MD N/A 10e. Street and Number	Baltimor		100	Citizen of What Cou	10€00 es 2 No
er death v Items 23s over must uneral	3301 Glenmore Avenue 11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 13.	21214 Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican,		U.S.A. 14. Race - Amer Black, White	ican Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygene. 27 is marked other than "natural", or traumatic avent. In Medical Evan To Be Completed by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ N 3 ☐ Widowed 4 ☐ Divorced	16a. Dece	1 ☐ Yes 2反 No Specify: dent's Usual Occupation kind of work done during most	of working	Specify: Who	
d 21215-0 filed within 72 hou Hygiene. sther than "naturn ent, the Wedfical e Completed	Elementary/Secondary (0-12) College (1-4or 5-3) 17. Father's Name (First, Middle, Last)	+) life.	er Worked	's Name (First, Middle, Ma	N/A	,
Maryland 2. 2 should be filed v n and Mental Hygie ris marked other t reumatic avent. II. To Be Col	Paul D. Gascoyne 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir		ria Bray		o Code)
ore, Ma	Gloria Pellicott 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	20b. Place of Dispo	Glenmore Aven		Maryland	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any injury or other	1	Parkwoo	2. Name and Address of Facility	Miller-DirPe	altimore, el Funeral	Home Inc.
Physician	23a. Part 1. Enter the disease, or complication and shock, or heart failure. List only the cause on each lin Immediate Cause (Final disease or condition resulting in death)		415 Belair Road er the mode of dying, such as c Prevma	ardiac or respiratory arrest	-	Approximate Interval Between Onset and Death
reate be executed physician and stree burial-transit calcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a donsequence of): a consequence of): a consequence of):				
P.O. Box 6876(that the death certificate be ed by the attending physicia detached for use as the but Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown 23c. If yes, outcome 1 □ □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	rery Day Year
of Vital Records, P Physician: The law requires that r this certificate has been signed t ral director, page 2 should be det	Part II. Other significant conditions contributing to death be Ceviloval pally, I Hypothyroidium, Rei	ut not resulting in the u Lub, fu Luxub	nderlying cause given in Part I. W(eV)	1 ☐ Yes 24a. Was an autopsy performe		bably 4 Unknown opsy findings available impletion of cause of
Sion tending Seath. tor: Afte the fune	25. Was case referred to medical examiner? 1 Yes 2 Yes 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injur	y Year) 28b. Time o Injury	Other: 4 Nurself 28c. Injury at Work? M 1 Yes 2 N	of Death (Check only one) sing Home 5 The Residence 28d. Describe how	ce 6 □Other (Speci	
Division Hospital or Attend Hours after dealth Funeral Director: Italy filled in by the	29a. Certifier 1 Certifying Physician: To the best of		h occurred at lihe time, date and	City or Town, S	State) se(s) and manner as:	stated.
To the Hosp within 24 hour To the Funer completely fil	(Check only one) 2 Medical Examiner: On the basis of and manner sta 29b. Signature and title of certifier		29c. License number	29d	B. Date signed (Month,	Day, Year)
State	30. Name and address of person who completed cause of de vision of the second of the s	eath (Item 23a) (Type,	Print) 0060 utous St. Su	, , , , , ,	altimore	MD 21201

		1	For State of Registrar	Maryland /		rtment of He			ene g. No. 0 0		32729
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	· · · · ·	3. Time of Death
	Physicia	an	Stewart J	unior H	ink1	P		October		Year 4	1:41 P M
	/Medic		a. Facility Name (If not institution, give street and number			4b. City, Town, or	Location of Death	000000	4c. County of		
	Examin	C1	University of Maryland Me		ntor	Ra1	timore			N	/A
	Consul		Social Security Number 6. Sex 7	. Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Vaasl	9. Birth	place (State or Foreign
	Funeral Director		214-40-9521 1X M 2 D F	61	Yrs.	Months Days	Hours Min.	(Month, Day, MAY 12.	1943	Vii	rginia
		t	Isual Residence of Decedent								
	ytan		0a. State 10b. County	10c. City, To	wn or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2 X No
	Ma-f-	ş,	aryland Baltimore			Catons	ville				
	or 28		Oe. Street and Number			10f. Zip Code		10	g. Citizen of W	nat Cou	ntry?
	23a (25 Shady Nook Avenue			21228			J	JSA	
	dea	ner	Marital Status 12. Was Deceded Armed Force	lent Ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Ameri	can Indian, etc.
9	or its	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Give	2 □ No	. 1	☐ Yes 2X No	Specify:		Specify:	Whi	.te
8	ours iral', Era		3 Widowed 4 Divorced Year or Da	les: 1967-68	3						
<u>ک</u>	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23s or 28s-f show thit, the Medical Evanher must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16	Give /	ent's Usual Occupa kind of work done of	ation furing most of work)	ing	16b. Kind of Bus	iness/in	idustry
2	within iene. r then	Id II	Elementary/Secondary (0-12) College (1-	4or 5+)					Floo:	rinc	•
2	filed w Hygiel other th	ပိ	7. Father's Name (First, Middle, Last)	Re	esiii	rent 1100	r Mechan				
Ē	be fi	Be						Leslie B		7	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiens. If item 27 is marked other then, "natural," or items 23a or 28a-f show or other treumatic event, the Healtest Evantines mast be notified at	2	Ernie P. Hinkle	10	Ob Mailia	n Address (Street :	and Number or Rura			State Zi	n Code)
<u>a</u>	and C		19a. Informant's Name/Relationship (Type, Print)			•	Avenue				
a)	tealth		Rondi C. Hinkle/Wife	20b. Place	of Dispos	sition (Name of			20c. Location - (
ō	ges forth		1 ☐ Burial 2 Cremation 3 ☐ Removal from S	tate cemet	tery, crem	natory or other plac					
Ë	men tent: jury		`4 □Donation 5 □Other (Specify)	Metro		matory,]			Baltimo	re,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health ar Importent: If Item 27 is any injury or other tret once.		21. Signature of Funeral Service Licensee Fdward A. Cregorchik	_	2	remation 99 Frede	s of Facility Society cick Road	of MD, I Baltimo	nc. re, MD	212	28
		-	23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. De	o not ente	er the mode of dyin-	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician	2 11	Immediate Course (Final	ior an Fa	ai 111r	· o					Onset and Death 3 days
	/Medical			or as a consequence							5 days
	Examiner		Муос	ardial In	nfarc	tion					4 years
15		ē	Sequentially list conditions, Lary La Jng to immediate cause. Enter Underlying	or as a consequenc	ce of):						
	cuted ad ransit	Examiner	Cause (Disease or injury that initiated events c. Diab	etes							
ó	an ar	EX	resulting in death) Last Due to (or as a consequenc	ce of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical	d							-	
9	tifica ig ph as th	Jed	IF FEMALE:								N
Вох	death certifica attending ph d for use as t	an/A	23b. Was decedent pregnant 23c. If yes, out	come of pregnancy rth 2 Fetal dea	ath 3□	Ectopic pregnancy			23d. Date Mon		very Day Year
	ne deat the att	hysician/Me	1 U Yes 2 U No o∏ttokno	ant at time of death wn	5 [Other (specify)					,
P.0	that the d ed by the detached	Phy	9 Unknown	-			- I- P-al	22a Did to		ibute to	the cause of death?
S,	Se U5 90	by	Part II. Other significant conditions contributing to de	ath but not resulting	g in the ur	nderlying cause giv	en in Part I.	4		3 X) Pro	
ord	w require been si should I	ted			·				35 2 110		
၁၁	N CO	ompleted						24a. Was a autops	y p	rior to co	opsy findings available ompletion of cause of
<u>~</u>	0 4 0	no:						perform		leath?	2 🗆 No
Vital Record	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					h (Check only on	8)		
of V	d is	2		npatient 2 ER/	Outpatien		4 D Mulaling I I	ome 5 Reside			ify)
	ng Ph Iter th neral		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of (Mont)	of Injury h, Day Year) 28t	b. Time of Injury	Wor	k?	28d. Describe ho	ow injury occurre	эd	
<u>Ö</u>	Attending ir death. ector: After by the fune	atle	2 Accident investigation				Yes 2 □ No				
Division	tel or Attending Ples after death. el Director: After the in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place building	of Injury - At home, ng, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number, State)	ar or Hui	ral Route Number,
	urs af urel D urel D		Vi o at a second	hant of1	dan deed	2 populared at the con-	no date and sizes	and due to the	2000(0) 254 ===	0001 00	stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1	asis of examination	and/or in	vestigation, in my o	pinion, death occur	red at the time, d	ate and place, a	ind due	to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed	(Month	, Day, Year)
	⊢ ≯ ⊢ ŏ		A Shows Delto	no n	12	RES	-000		October	9.	2004
7	141		30. Name and address of person who completed caus	e of death (Item 23	a) (Tyne					- ,	,
	5.7			E. Cleme			altimore	MD 2123	30		
	St	ate	31. Date filed (March Say Year) 32. R	gistrar's Signature				111/41/40			
	Regist		00119 2004	Revera	0	Spark					

			Plea	se Type or Pri							egible.	
			For State Registrar	State of M	aryland		artment of rtificate of	Health and I Death	Mental H	ygiene Reg. No.		32730
Т			Decedent's Name (First, Middle	e, Last)					2. Date of D	eath	7 7 7	3. Time of Death
	Physici /Medi Examir	cal	Thomas J. Howa:				4b. City, Town,	or Location of Death	Month		Year 2004 County of Death	6:49 p
	LXaiiiii	ICI	Franklin Woods	Nursing Hom	e			Essex				•
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of 8		ltimore 9.Binth	place (State or Foreign
I.	Director		218-03-5339	1 M 2 □ F	8	3 Yrs.	Moritins Days	Hours Will.	Jul 16			intry) Zland
	and		Usual Residence of Decedent 10a. State 10b. County		10c, City.	Town or Lo	cation				-	10d. Inside City Limits
	/anyli	ŏ					oation					1 ☐ Yes 2 ♣ No
	the the 286-	Director	PA York 10e. Street and Number		Hanc	ver	10f. Zip Code			10g Citize	en of What Cou	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other then "neturel", or Items 23e or 28e-f show or other treumetic event, the Mydical Examinar must be routiled at											,
	ms 2	Funeral	34 Highview Dri 11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	17331 Was Decedent of	Hispanic Origin? (Span, Mexican, Puerl	pecify Yes or N		ed Stat 4. Race · Amer	
g	or Ite	Ξ	1 ☐ Never Married 2 ☐ Marr						Rican, etc.)		Black, White	
93	rel', c	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	IIWW		1 ☐ Yes 2 🗷 No	Specify:		S	Specify: Whit	2
2	72 h	etec	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	lent's Usual Occu	during most of won	kina	16b. Kind	d of Business/Ir	
2	Mithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	i+)	`life. L	OO NOT use retire	ed)	9	Const	tructio	n
N T	Hygie Hygie Ther t		12. 17. Father's Name (First, Middle,	(act)		Maste	r Carpen		- /First Mintell	14-14 0		
Maryland 21215-0036	d be f	Be c						18. Mother's Nam			umame)	
<u> </u>	shoul nd Me mark meti	ဥ	John Joseph Ho 19a. Informant's Name/Relations			19b Mailin	ng Address (Street	Loretta t and Number or Ru			Tour State 7	Codel
Z	od 2 s Ith ar 27 ls		Mrs. Diane Knox							•		(Code)
ē,	i Hea i Hea item othel		20a. Method of Disposition	Daughter	20b. Plac	e of Dispo	sition (Name of	rive, Han	Date		ation - City or T	own, State
Ê	Page ento nt: If		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S				natory or other pla		Oct 16	Polto	sville,	MD
altimore,	permil. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or other treu once.		21. Signature of Funeral Service	Licensee		22	ce Crema. Name and Addre	ess of Facility	2004			MD
m	Departiment of the permitted of the perm	0	Sett	well mo	0986	0	remation	n and Fune en Pasture	eral Al	ternat	tives	MD
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the death.	Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,	LCIMOLE	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition URINIARY TRACT INFECT									Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):									
	Examiner		Sequentially list conditions, b									
	be sit	Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseque	nce of):						
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):						
9	be ey			00000000	a conseque	ice or).						
687	The law requires that the death certificate to the has been signed by the attending physic bage 2 should be detached for use as the to the total t	Physician/Medical		d								
Box	certif nding use a	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc	у	_			22	d. Date of delive	200
ň	death a atter	iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnanc Other (specify)	у		23	Month	Day Year
0	at the de by the tached	hys	9 Unknown	9□ Unknown								
ώ.	res that igned b	by P	Part II. Other significant condition	ons contributing to death b	ut not resulti	ng in the un	derlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to t	ne cause of death?
ğ	aquire an sig ould b	ed t	PROSTAT	ECANO	ER	, (0	RONAR	Y	1 🗆	Yes 2	No 3□Prob	eably 4 Unknown
Records,	aw requisits been 2 should	Completed	PROSTAT	O(SEASE.	PER	IPH.	ERAL		24a. Was		24b. Were auto	psy findings available
ř	The hare hare hare	E O	VASCULA	A DISE	45F				auto perfo	psy ormed? 20 No	death?	mpletion of cause of 2 ≰ No
Vital	sicien: The law certificate has b irector, page 2 s	Bec	25. Was case referred to medical examiner?					26. Place of Deat		/	10 163	24110
O TO	Physic this ce al dire	To.	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 EF	VOutpatient	3□ DOA Oth	ner: 4 Nursing Ho	me 5 Resi	dence 6 [Other (Specif	y)
ב ס	ding Ph h. After th funeral	on:	27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of Injur (Month, Day	y Year) 28	Bb. Time of Injury	28c. Injui Wor	ry at	28d. Describe			
<u>s</u>	Vttendi death. ctor: A y the fu	cat	2 Accident investigation M 1 ☐ Yes 2 ☐ No									
DIVISION	after date de Direct	Certification;	4 ☐ Homicide determ		iry - At home :. (Specify)	e, farm, stre	et, factory, office		28f. Location (City or To	Street and M wn, State)	Number or Rura	l Route Number,
_	Hospitel 4 hours a Funerel C		29a. Certifier 1 Certifyin	a Physician: To the heart	of my beaut	ndge dest	Occurred at the co	me data and 1				
	the Hospitel or Attending Physicien: in 24 hours after death. The Funerel Director: After this certification in by the funeral director,	edical	(Check only one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination	and/or inv	estigation, in my c	me, date and place, opinion, death occur	and due to the ed at the time,	cause(s) an date and pl	nd manner as si ace, and due to	ated. the cause(s)
	To the Hospitel within 24 hours a To the Funerel to completely filled	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)
	/V_i		Di f	arshall			De	t000 8		10	1101	04
-	1500	-	Jum 1					1 - 0		-10	1151	

DHMH 17 Rev 1/2001

State Registrar FRANKLIN SQUARE DR. BALTIMORE, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JIM PARS'HALL 9105 FRAN

32. Registrar's Signature

JIM PARS'HALL
31. Date filed (Month, Day, Year)

OCT 1 5 2004

		-	For State	END ITEM A	State of Ma	-	•					giene	nal.	00701
	0		Decedent's Name	(First, Middle, Last)	FZU FISK VI	GVD G	0.30	U/1//UH		2.	Date of Dea	ath 1	V	3. Time of Death
1	Physicia /Medic	al .	Edwin		Stanley		Не	rness			Month Octobe			
	Examin	er		f not institution, give				4b. City, Town,					County of Deati	
				rundel Hos		. // /-		Glen If Under 1 Year			Data of Bird		ne Aru	
	Funeral Director		 Social Security N 198-22-3 	. 7.7	7. Age M 2□F	e (In yrs. Ia: 75	Yrs.	Months Days		Min.	Date of Birtle (Month, Day (May 1,	y, Year)	9. Bini	nplace (State or Foreign untry) nsylvania
	D		Usual Residence of											
	arylar ahow	_	10a. State	10b. County	1.1		Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f a	octo	MD	Anne Aru	naeı	Ud	enton					40 - 011	en of What Co	
	with t	Ē	10e. Street and Nur	e Avenue				10f. Zip Code 211	12			•	USA	unity :
	eath	eral	11. Marital Status		12. Was Decedent	Ever in U.S.	. 13.	Was Decedent of f Yes, specify Cub		Origin? (Specif	y Yes or No-		4. Race - Ame	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. If marked other than "natural", or Itams 23a or 28a-f ahow itam 27 is marked other than "natural", or Itams Ear Cilified at other traumatic event, the Medical Exactinational tear of the control of the contr	by Funeral Director			12. Was Decedent Armed Forces? 1 XX Yes 2 ☐ N If Yes, Give Year or Dates:			f Yes, specify Cub 1 □ Yes 2X1 No			án, etc.)		Black, White Specify: Wh	
21215-0036	oe filed within 72 hours a at Hygiene. at Hygiene. I other then "naturel", o ivant, the Medical Even	Completed by	(Spec	15. Decedent's Edu ify only highest grad	cation e completed)		(Give	dent's Usual Occu kind of work done	during me	ost of working		16b. Kin	d of Business/	Industry
121	within ine. ihan	mpl	Elementary/Seco	ndary (0-12)	College (1-4or 5			00 NOT use retire ant Firs		966		T	J.S. Ar	m 3.7
73	Hygie Hygie thar ant, th	ပိ		(First, Middle, Last)			Derge	ane iiis	T	ther's Name (F	First, Middle.			
Maryland	s 1 and 2 should be 1 Health and Menta! Itam 27 ia markad o other traumatic ava	To Be		J. Hernes	s				E1:	izabeth	Cashi	imer		
ary	shou and M a mar	-	19a. Informant's Na	ame/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (Stree	t and Num	ber or Rural F	Route Numbe	r, City or	Town, State, Z	Tip Code)
Σ.	and 2 salth a 127 is ar tra		Mildred	I. Hernes	s (Wife)				enue					
ore	iges 1 it of He if itan or oth				Removal from State	20b. Pla	ce of Dispo netery, crer	sition (Name of natory or other pla						
Ë	Pag tment tant: jury o		` 4 □Donation	5 Other (Specify)		Mar	-			-			msvill	e, MD
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other <u>ance</u> .		21. Signature of Fu	Hardesty Funeral Home P.A. 12 Kidgely Avenue, Annapolis, MD 21401 Approximate Approximate										
			23a. Part1. Enter t shock, or hea	he disease, or compl nt failure. List only o	ications that caused ne cause on each li	the death. ne.	Do not ent	er the mode of dy	ing, such a	as cardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause		carc	tion	rasi	cular	de	seas	٩			Oliset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a conseque								
	TE S	er	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	b. Due to (or	a conseque	ence of):	un						
	uted d ansit	Examin	cause. Enter Under Cause (Disease or that initiated events	injury	dia	bete	7							
o,	be executed ician and burial-transit	Еха	resulting in death)	Last	Due to (or as	a conseque		1 .	0.	1				
68760,	ate thys the	edical		(d. Try	perc	hol	estero	len	na				
			IF FEMALE:		23c. If yes, outcome	of pregnan	CV				·	21	3d. Date of deli	ivon
Вох	atte	Physician/M	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal of	death 3	Ectopic pregnand Other (specify)	су			2.	Month Month	Day Year
O.	by the tached	ysi	1 Tes 2 Dunknown		9□ Unknown			() // -						
4	requires that the een signed by th hould be detache	by Pl	Part II. Other signi	ficant conditions co	ntributing to death b	out not resul	ting in the u	nderlying cause g	iven in Par	rt I.	23e. Did to	obacco us	e contribute to	the cause of death?
rds	w require been sig should b										1 🗆 \	es 2	No 3□Pr	obably 4 Unknown
Records,	aw as b	Completed									24a. Was autop		24b. Were au	topsy findings available completion of cause of
H	The ate h page	Com									perfor	rmed? 2 No	death?	2 No
Vital	ician: certifica rector, p	Be (25. Was case references							ce of Death (0.1
of	Physic this c al dire	^L	1 Yes 2	INO	Hospital: 1 🗀 Inpation	-	R/Outpatier 28b. Time o	IL STATOON			d. Describe h		Other (Spec	city)
no	ding h h. After funer	tlon	27. Manner of Dea 1 Natural	5 Pending investigation	(Month, Da	y Year)	Injury	We	ork? ⊡Yes 2∣		u. Doscribe i	iow injury	occurred	
Division	Attanding Physician: r death. actor: After this certific by the funeral director,	flca	2 Accident 3 Suicide	6 Could not be	280. Place of in			reet, factory, office			f. Location (S	Street and	Number or Ru	ıral Route Number,
Div	alor/ s after il Dira	Certification:	4 Homicide	determined	building, et	tc. (Specify)					City or Tox	vn, State)		
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fo	Medical C	29a. Certifier (Check only one)	Certifying Phy 2 Medical Exam	vsician: To the best iner: On the basis o and manner st	of examination	rledge, deat on and/or in	h occurred at the vestigation, in my	time, date opinion, d	and place, an leath occurred	d due to the at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To tha within 2 To the comple	Me	29b. Signature and	title of certifier	0 - 0	1	0 1	29c. Licer				29d. Date	signed (Monti	h, Day, Year)
	_		> 5)	Music	Roses	ye	CC /	40 D2	268	5		10/1	2/04	1
	13			ress of person who c				Print) e, Glen I	Rurni	e. MTh	21061	1	,	
	St	te.	31. Date filed (Mor	Rosenfeld oth, Day, Year)		pitai rar's Signati		/		، سد و				
**	Regist		OC	T 1 5 2004	Schen	~ /		sporks	/					

			1 - For State Registrar	State of Maryl		artment of He	ealth and	Mental Hygie	ne 2001	32733
	Dhyoisi	-	Decedent's Name (First, Middle,	1				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		Nancy		Rtma	N.		OFTOBLA	HOOK 01	10:12 PM
7	Examir	ner	4e. Fecility Name (If not institution,			4b. City, Town, or	Location of Deat	n	4c. County of Deatl	
			101 F Oour			BELMI	Klinder OAllin		HARFOR	
	Funeral Director		5. Social Security Number 33-53-7596 Usual Residence of Decedent	3. Sex 1 □ M 2 0 F. 7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Day, Ye	9. Birth	place (State or Foreign intry) VLANO
	hours after death with the Maryland tural', or Itams 23a or 28a-f ahow all Examinational be notified at		10a, State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	death with the Marylar ns 23a or 28a-f ahow mat be nofffed at	to	MARLAND HAR	F0RD	Bel Ri	R				1 ☐ Yes 2 No
	or 28	Directo	10e. Street and Number	0		10f. Zip Code		10g.	Citizen of What Co	intry?
	ath w	ral	1077 DONDEN	DRIVE		2101	4		V.S.F	(-
	ter dea Itams Itams	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
36	ours after o al', or Itan	by F	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 250 No If Yes, Give Year or Dates:		1□Yes 21 No	Specify:		Specify: 1	477
21215-0036	72 hours "natural", dical Exi	ed	15. Decedent's		16a. Dece	dent's Usual Occupat	tion	16h	Kind of Business/l	J(112
215	.⊆ ~ 31	Completed	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work done du DO NOT use retired)	urina most of wor	king	Traine of Desiriossyl	idustry
21	led with lygiene. her than	Com	29/181	3.7 RS-	Bo	OKKIZAZ	iR	\ \	Snionz	
pu	# H # #	Be (17. Father's Name (First, Middle, La				18. Mother's Nan	ne (First, Middle, Maid	en Sumame)	
yla		2		2AMORTI. 1			L1.70	(\$D). 3	HORN	
Maryland	s 1 and 2 should t Health and Men itam 27 is marke other traumatic		19a. Informant's Name/Relationshi		19b. Mailir	ng Address (Street ar		ral Route Number, Cit	y or Town, State, Zi	p Code)
	1 and 4ealth am 27 ther 1		20a. Method of Disposition		b. Place of Dispo	DONIEN.	DRIVE.	BELLIAR 1	(ARYLAC	0 21014
و	90 = 5		f Burial 2 ☐ Cremation 3	☐Removal from State	cemetery, crei	matory or other place	100	Date 20c.	Location - City or T	own, State
Baltimore	0 9 5 5		* 4 □ Donation 5 □ Other (Special Signature of Juneral Service Li		ARKWOO			1077 LB	RKVILE	1 LARYTON
Ba	Deportm Deportm Importer any injui		21. Signature of uneral Service Li	2 votu	22	2. Name and Address	of Facility 6	ctimore,	mD 21	234
200			23a. Part 1. Enter the disc se, or 6	omolications that caused the d	eath. Do not ent	er the mode of dving	Such as cardiac	HAPEL, 880	OHARFOR	Approximate
1	ga Pro		23a. Part1. Enter the dissess, or of shock, or heart filter. List of Immediate Cause (First	ily one cause on each line.		The state of the s	, 00011 00 001010	or respiratory arrest,		Interval Between nset and Death
	Pnysician [*] /Medical		disease or condition resulting in death)	a. Due toor as a cons		non				5 months
	Examiner			Anor	OXIA					LUGAR
0		Je.	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying	b. Due to for as a cons	sequence of):	•				1 9000
	cuted nd ransit	Examiner	that initiated events	1. ScM	100 DV	renia	L			Sugars
Ö,	te be executed ysician and se burial-transit		resulting in death) Last	Due to (or as a cons	sequence di):					
8760	# 5° E	lical	•	d						
9	death certifica e attending ph od for use as ti	Physician/Med	IF FEMALE:	00-16						
Вох	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of prediction 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
P.O.	the de	ysic	1 □ Yes 2 🗷 No 9 □ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify)				
-	uires that the de	F.	Part II. Other significant condition	s contributing to death but not	resulting in the ur	nderlying cause given	n in Part I.	23e. Did tobacci	use contribute to I	he cause of death?
rds	quires n sign	d by						1 ☐ Yes	2XNo 3∏Proi	oably 4 Unknown
Records,	The taw requires ate has been sign page 2 should be	Completed						24a. Was an	24h Wara auto	ppsy findings available
Re	The tav te has age 2:	ошо						autopsy performed?	prior to co death?	impletion of cause of
ta	iicien: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of Dea	th (Check only one)	lo 1 Tes	2 L No
>	Physicien: r this certifica ral director, p	To B	examiner? 1 □ Yes 201 No	Hospital: 1 Inpatient 2	! ☐ ER/Outpatien	Othor		1000	6 □Other (Special	(v)
0	ding Pt T. Atter th funeral	ü	27. Manner of Death 1 ☑Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injury a Work?	at	28d. Describe how in		,
Sio	ttendii death. stor: Ai	catic	2 ☐ Accident investiga	tion			es 2□No			
Division of Vital	l or Attenate after death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determine	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location (Street : City or Town, Sta	and Number or Rur te)	al Route Number,
	pital ours a eral [200 Codding A Codding	Sharining Total Land						
	24 hos 24 hos Fun etely	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of my keminer: On the basis of examand manner stated.	nowledge, death ination and/or inv	occurred at the time restigation, in my opir	, date and place, nion, death occur	and due to the cause red at the time, date a	s) and manner as s nd place, and due t	tated. o the cause(s)
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier		18	29c. License r	number	29d. D	ate signed (Month,	Day, Year)
)	1		TYYOU	187	MD	Dis	5827	Oc	tober 13	,72004
	h		30. Name and address of person wh	o completed cause of death (I	tem 23a) (Type,	Print)	1.44	011	010	4: 0
	1		Colynn N	1. Wells, 1	UD,	560 U	. Mae	Mail,	1sel Hr	MP. 21014
	Sta Registr	_	31. Date filed (Month, Day, Year) CCT 1 5 204	32. Registrar's Sig	gnature	Goald				

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		•	For State Registrar	State	of Marylar		artment of H		Mental Hyg	iene	32734	
			Decedent's Name (First, Middle	, Last)					2. Date of Deat	h	3. Time of Death	
	Physicia		ROBERT KARL I	RLBACHER					Month OCTOBER	Day Year 14, 200	. O 1 E A M	
	/Medic Examin	_	4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea		4c. County of De		
			DULANEY VALLEY	ASSISTED	TED LIVING BALDWIN			ALDWIN		BALTIM	ORE	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. Bi	rthplace (State or Foreign Country)	
	Director		210-05-6043	1 ∑ M 2∏F	84_	Yrs.	Mortals Days	TIOUIS IVIII	2/17/19		NSYLVANIA	
	р ,	-	Usual Residence of Decedent		100 0	h. Town or la	antina				10d Incido City Limite	
	show	_	10a. State 10b. County		100. 0	ity, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🖫 No	
	Ba-f	cto		FORD	J.	ARRETTS						
	ith th	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	Country?	
	death with the Maryland ms 23a or 28a-f show Enast be collified at		3663 FALLSTON				2108			USA	USA 14. Race - American Indian,	
	d within 72 hours after death with the Maryla piene. Ir then "natural", or items 23e or 28e-f show I've Medical Exercities court be scottled at	Funerai	11. Marital Status	Armed F		J.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Hace - Am Black, Wh		
20	s afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Vac C	2 □ No Sive Dates: WWII		1 ☐ Yes 2 ☑ No	Specify:		Specify: WH	TTF	
2-0036	within 72 hours after ene. than "natural", or ite na Meulcal Evanilia		15. Deceden		Dates. WWII	16a Dece	dent's Usual Occup	ation		16b. Kind of Busines		
ဂ်	in 72 "na ledic	Completed	(Specify only highes	t grade completed		(Give	kind of work done	during most of wo	orking	Too. Time of Dagsing	a made in	
7	with ene. thar	шс	Elementary/Secondary (0-12) STH GRADE	College	(1-4or 5+)	FTNI	SHER			TOOL MANU	FACTIBING	
0	at the		17. Father's Name (First, Middle,	Last)		1 1 1111	Dilli	18. Mother's Na	me (First, Middle, I		ROTORING	
a	Mental Mental arked o	To Be	JOSEPH E. IRL	BACHER				MARGA	RET WATSO	N		
⋛	d 2 should th and Men 7 is marke traumatic	F	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)	
<u>8</u>			JOHN R. IRLBACH		SON	3663	FALLSTON	ROAD J	ARRETTSVI	LLE, MD	21084	
ည်	Health Health tem 27 other tu	91 9	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of	1	Date	20c. Location - City o	r Town, State	
galtimore	Pages nent of int: If it ury or o		1 Donation 5 ☐ Other (S		n State		natory or other plac AH CEMETE		18/04	TOWSON, M	D	
	permit. Pag Department Importent: eny injury once.		21. Signature of Funeral Service.		PII						HOME, P.A.	
ñ	permit. Pages 1 and Department of Health Importent: If item 23 eny injury or other to		1 M. Meal C	dance			21 LOCH				1206	
	S W		23a. Part1. Enter the dis-se, or shock, or heart failule. List	complications that	caused the dea						Approximate Interval Between	
	Dhusisian), [Immediate Cause (Final	only one cause on	LIVI And	M.	IM PAN				Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to	(or as a conse	quence of):	EN 1- 1/10	1				
	Examiner			Duo ((01 43 4 001130	quonos or).	1	1				
h		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	o (or as a conse	quence of):						
	uted	Ë	cause. Enter Underlying Cause (Disease or injury that initiated events	S .								
ĵ.	exec n an ial-tr	Examiner	resulting in death) Last	Due to	o (or as a conse	quence of):						
9	death certificate be executed e attending physician and but for use as the burial-transit	dicai		d								
200	tifical g ph	edi										
X R Q	leath certific attending p	N/u	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic pregnancy	,		23d. Date of d		
	deat	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)			Month	Day Year	
J.	The law requires that the de ate has been signed by the r bage 2 should be detached	Physician/Me	9 🗆 Unknown	1								
	es that igned to be deta	by F	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.			to the cause of death?	
ğ	w require been si	ed			· ·				1 □ Ye	es 2□No 3□F	Probably 4 Dunknown	
Records ,	e law re has be je 2 sh	ple							24a. Was a autops		autopsy findings available completion of cause of	
	: The l	Completed							perform	ned? death?		
Vital	Physician: this certifica	Be	25. Was case referred to medica examiner					26. Place of De	ath (Check only on	e) ACCTO	STED LIVING	
	hysic nis ce I dire	Lo	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing	Home 5 ☐ Reside	ence 6 X Other (Sp	ecity)	
0	ng PI		27. Man or of Death 1 Vatural 5 ☐ Pendir		e of Injury onth, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred		
0	death. ctor: #	ati	2 Accident investi	gation			M 1	Yes 2 □ No				
Division of	r Att ter de irect	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 200. Fla	ce of Injury - At I Iding, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,	
	itel c irs af rei D					2.20	-07/2		M	3 B	SV 1935 - 1945 - 1945 - 1945	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerei Director: After this certific completely filled in by the f. neral director.	Medical	(Check only 2 Medical	Examiner: On the	basis of examin					ause(s) and manner a ate and place, and du		
	the the mpler	Med	one) 29b. Signature and title of certifie		inner stated.		29c. Licens	e number	2	9d. Date signed (Mor	oth Day Year)	
	J N L		LIE GIAD /	Ma			DIG	1/42		10/15	L / I	
	avl	1	77 707 71	IV I	una of decision	23-1 (**	Print)	V71L		10 113	04	
	121		70. Name and address of person	wno completed ca	use of death (Ite	m 23a) (Type,	iAAA(//)	Ans	HOL	mn >	1078	
	1 °	10	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	ועטן יעעע	1/00	11/0	1/1/	10/0	
	Sta Registi			. /	D. Jane	4	Ann Val	,				
DI	JMH 17 Pay 1/2	001	OCT 1 5 2	004 /2		1	and a second					

DHMH 17 Rev 1/2001

ORIGINAL

			For Stete Registrar	State of	Maryland	•	artment of H				iene	70 mm	35705	
H	o Physici	an	1. Decedent's Name (First, Middle,		Jac	Rsor	1			2. Date of Deat		Year //	3. Time of Death	
	/Medic Examin	al	4a. Facility Name (If not institution,	give street and num			4b. City, Town, c	r Location o		october	4c. County o	OO 4 of Death	12 or Norm	_
	Funeral Director		Good Samaritan 5. Social Security Number 218-07-6938		7. Age (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 7-26-1	Year)	9. Birthp Coun	lace (State or Foreign try)	_
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					11	0d. Inside City Limits	-
	ne Mar Be-t sl	Director	Md.	NA		Balt	imore						Y Yes 2 □ No	_
	with the	Dire	10e. Street and Number	A N	» -	210	10f. Zip Code			1	0g. Citizen of W		try?	
	Jeath ms 23	Funeral	1651 E. Belve	12. Was Dece	dent Ever in U.S	310 s. 13. v	21239 Was Decedent of F	lispanic Ori	igin? (Spe	ecify Yes or No-		- Americ	an Indian,	_
0000	be filed within 72 hours after death with the Maryland Hygiene. d other then "neturel", or tlems 23e or 28e-t show do other then "neturel", or tlems 24e or 28e-t show event. The Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ Marrie 3 🅱 Widowed 4 ☐ Divorced	Armed For 1 Yes If Yes, Giv Year or Da	2 XNo e		f Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexicar Specify:	n, Puerto	Rican, etc.)	Specify:	, White, o	etc. ack	
֖֭֡֝֟֝֝֟֝֓֟֝֟֝֟֝֟֓֓֓֓֟	72 hou		15. Decedent's		55	16a. Deced	dent's Usual Occup	ation	at of worki	ina	16b. Kind of Bus			Į
	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	`lifa. I	DO NOT use retire	d)		·	Orman (miame Cham	
7	e filed within al Hygiene. I other then " vent, Ine Me	e Co	9th grade 17. Father's Name (First, Middle, L	.ast)		- SE	lf-Emplo	-	er's Name	(First, Middle, M			nient Store	3
	should be nd Mental marked o	To Be	Herman	in (Time Briet)	Harr		ng Address (Street	Len	-	of Claude Alumba	Pai	~	Code	
2	8 a a		19a. Informant's Name/Relationsh Gertrude Thoma		ce		.700 Meri					_	1239	
ē,			20a. Method of Disposition			lace of Dispo	sition (Name of natory or other pla	1			20c. Location - (City or To	wn, State	7
ашшог	nit. Pages artment of ortent: If it injury or o ®.		1 Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (Sp	3 ∐Removal from S ecify)	State _		re Cem.		10-1	6-04	Baltim	ore,	Md.	
pall	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service L	icensee	av J		Name and Address		•	Ba 1101 E.	ltimore North	/ Mđ Ave.	. 21202	000
	Physician /Medical Examiner the prial-transit	dical Examiner	23a. Part. Enter the disease, or cannot shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Run Due to (c) b. Due to (c) c. Pue	or as a consequence of as a consequence of a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a	Januardo of): unle usence of): unle usence of):	er the mode of dying Hear Hear Vas			eture deri		1	Approximate Interval Between Onset and Death The World Worl	
BOX D	e death certific he attending p led for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bi	come of pregnar irth 2 ☐ Fetal ant at time of de own	death 3	Ectopic pregnanc	у			23d. Date Mon		ry Day Year	
ds, r	es ign be	by	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the u	nderlying cause giv	en in Part I	l.	23e. Did tob	_	bute to th	e cause of death?	
Kec	The law ate has b page 2 sl	Completed								24a. Was an autops perform	y pr ned? de	ior to con eath?	osy findings available npletion of cause of	-
Vital	Physicien: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ott			(Check only on				_
on or	Jing After fune	tlon; To	1 Yes No 27. Manner of Death 1 Natural 5 Pending investig	28a. Date of		ER/Outpatien 28b. Time of Injury	28c. Injui	4 ZUN I		me 5 Reside 28d. Describe ho			')	-
UNISION	al or Attending F s after death. I Director: After d in by the funer	ertification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, office			28f. Location (St. City or Town		r or Rura	Route Number,	-
_	Hospite 24 hours Funere etely fille	edical C	29a. Certifier 1 ★Certifying (Check only 2 Medical E	g Physicien: To the Exeminer: On the ba and mann	asis of examinat	wledge, death ion and/or inv	n occurred at the tile vestigation, in my o	me, date ar opinion, dea	nd place, ath occurr	and due to the ca	use(s) and man ate and place, a	ner as st	ated. the cause(s)	-
	To the within To the compl	Me	29b. Signature and title of certifier	Try	pena	em	29c. Licens D 3	o 66	1	29	eto be	(Month, l	Day, Year) 2004	-
	3		30. Name and address of person v	yno completed caus	e of death (Item	23a) (Type,	Print Ball	in	ore	· rea	1-21	23	9.	
	Sta Regist		31. Date fil 900 111 Dg. 7200		egistrar's Signat		park							

Mercy E. Jones 04-6599 DOS

			1- State of Maryland / D Registrar Amend Item 19a per fh G836 10	epartment of Health and Me 15-04 tas Certificate of Death	ntal Hygien Reg. N	e nn. 97796
	Di-	April 1	Decedent's Name (First, Middle, Last)	2.	Date of Death Month	3. Time of Death
	Physici /Medi		MERCY E.		October 1	12, 2004 1512 p M
4	Examir	er	4a. Facility Name (If not institution, give street and number) 2102 Vine Street	4b. City, Town, or Location of Death	4	c. County of Death
	F		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Baltimore Hunder 1 Year Hunder 24 Hrs. 8	Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		TO A STATE OF THE	Months Days Hours Min.	Date of Birth (Month, Day, Yea	1941 VIRGINIA
	pu. »		Usual Residence of Decedent	out coation		
	Maryland -f show	ž	10a. State 10b. County 10c. City, Town	0	1.	10d. Inside City Limits 1 ☑(Yes 2 ☐ No
	the M	Director	10e, Street and Number	10f. Zip Code	100 0	Citizen of What Country?
	3a or 28a	١	2102 VINE STREET	2/223	3	/1 < A
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - American Indian,
36	72 hours after natural', or Ita lical Evalena	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 🗖 No Specify:	A11, 610.)	Black, White, etc.
5-0036	hour tural		3 ☑ Widowed 4 ☐ Divorced Year or Dates:	Decedent's Usual Occupation	166	Kind of Business/Industry
215	nin 72 in "na Medis	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	100.	Killa of business/industry
21	e filed within al Hygiene. I other than " vent, the Me	Com		URSING ASSISTA	NT N	URSING HOME
nd	uld be file fental Hy rked oth tic event	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	irst, Middle, Maide	en Sumame)
Maryland	2 should be and Mental Is marked (saumatic ev	P	JAMES WILLIAM PA	VNE MERCY Vailing Address (Street and Number or Rural R	DELLA	BROWN
Mai	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. itam 27 Is marked other than "natural", or itams 23a or 28a-f show other traumatic event, it a Madical Exammet must be notified at		Commander Jones (son)	Mailing Address (Street and Number or Hurri R	loute Number, City	
e,	s 1 and f Heal		20a. Method of Disposition 20b. Place of	Disposition (Name of Date	3/./20c.	ALTO, MO. 21223 Location - City or Town, State
9	e = 5		Burial 2 Cremation 3 Hemoval from State	crematory or other place) NPARK CEME 10-18	-04 B	ALTIMORE, MD.
Baltimore,	permit. Pages 1 a Department of Hez Important: If itam any injury or otha		21. Signature of Funeral Service Licensee			FUNERAL HOME
<u> </u>	8 9 E 8 6		Letuch N. Williams	2140 N. FULTON	AVE. B	ALTO. MO. 21217
п			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	et enter the mode of dying, such as cardiac or re	espiratory afrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Hyputeusue A	Hiposelepote Caclie	mula	Inches and Dealin
	Examiner		Due to (or as a consequence of):		
	*	ier	Sequentially list conditions, if any, leading to immediate to the to for as a consequence of)·		
	cuted nd ransit	Examiner	dia by bading to firm odate cause. Enter Underlying Cause (Disease or injury that initiated events c			
8760,	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):		
687	ficate be physicia s the bur	edical	d			
Вох	leath certifi attending I for use as	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery
-	0 0	by Physician/M	1 Yes 2 No 4 Pregnant at time of death	5 ☐ Other (specify)		Month Day Year
P.0	requires that the de een signed by the a nould be detached t	Phy	9 U Onknown		oo. Didustria	
ds,	Se Life		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.		use contribute to the cause of death?
of Vital Records,	> 0 0	Completed				
Re	B 8 03	duc			24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death?
ta	(G) L	0	25. Was case referred to medical	26. Place of Death C		o 1 Yes 2 No
Υ	Physician: this certific ral director,	To B	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	Other		expother (Specify) at scene
0			27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Tir	ne of 28c. Injury at 28d ury Work?	. Describe how inju	
Sio	Attanding r death. actor: After by the funer	icat	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	1 - 4 - 40 - 4	
Division	l or A	Certification:	4 Homicide determined 28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office 281.	City or Town, Star	ind Number or Rural Route Number, te)
	To the Hospital or Attano within 24 hours after death To the Funeral Diractor; completely filled in by the		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and	due to the cause(s	s) and manner as stated.
	he Ho in 24 I he Fu pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occurred a	at the time, date ar	nd place, and due to the cause(s)
	To the within 2 To the complet	3	29b. Signature and title of certifier	29c. License number		ate signed (Month, Dey, Year)
	1-11		I bevolve M. Kaf mes	OCME		tober 13, 2004
1	(1)		30. Name and address of person who completed call of death (Item 23a) (THE ODDREMIKED)	111 Penn Street,	Baltimor	e, Maryland 21201
	Sta	te	31 Date filed (Month, Day, Year) 32 Registrar's Signature			
	Registi		OCT 1 5 2004 Janua Ja			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 8:52 PM THOMAS WESLEY KEITH 2004 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1 XM 2 ☐ F Yrs. Director 217-74-1480 JUNE 1,1925 MDUsual Residence of Decedent with the Maryland 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23a or 28e-f show other traumatic event, Ire Madical Examinar must be notified at MD BALTIMORE 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1803 THORNBURY ROAD 21209 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. In and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) N/AN/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TURNER KEITH FANNIE KEITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m eny injury or other traum QDG. LAVERNE BROOKS/CASE WORKER 1803 THORNBURY ROAD BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BETHESDA U.M. CEMETERY 10-18-04 BETHESDA, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS STREET BALTIMORE, MARYLAND 2127 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMONARY Immediate Cause (Final EDEMA Physician 5 minul3 disease or condition resulting in death) /Medical ROCAL INFARCTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine EROTIC CARDIOVAS CULAR DISEASE use as the burial-transit Box 68760 LIPIDEMIA 40 YEARS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed NTAL RETARDATION 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? HYPERPLASIA PROSTATIC BENICH 2 No 1 Yes 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 3D DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of e Hospital or Attending P 24 hours after death. e Funerel Director: After ti 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funerel Completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier Ramina gopalin MD. 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

RAMANA GOPALAN MA ZE. KOLLING CROSS RUADS #159 BALTIMURG
MD 2122 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 5 2004

DHMH 17 Rev 1/2001

Keith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Joan Μ. Kyler Month 10 12 2004 1:55p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Joppa Rd. Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Yrs. Director 54 4-29-50 212-58-2042 Md. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumatic event, it a Medical Examinar mainte notified at Yes 2 □ No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2555 Cecil Ave 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filled within 72 hours after Department of Health and Mental Hygiene. Inforcent: if item 27 is marked other than "natural", or itel may injury or other treumetic event, tre Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pandora Raymond Wilson Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Wilson 2555 Cecil Ave., Baltimore, Md. Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10-18-04 1 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 W lady W aner March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Oreast Canc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Mnknown 1 Yes 2 No 3 Probably Varis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 3 No 1 Yes 2 100 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 1 InNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. Ligense number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) OCT 1 5 2004

32. Registrar's Signature

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Theodore C. Houk, M.D. 7825 York Road Baltimore, MD 21204

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			Decedent's Name (First, Middle, Las	t)					2. Date of De	ath		3. Time of Dea	ith
н	Physici		Gary Donald Kreis	ء ا					OCTOBEI	Day R R	2004	3:46P.	М
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1	Examin						VILLE	211011 01 200			TIMORE		
			1715 ABERDEEN ROAD 5. Social Security Number 6. Se		(In yrs. last birthday			Inder 24 Hr	S. 8 Date of Bird				reinn
	Funeral Director		215-60-5171	M 2□F	51 Yrs.			ours Mir		y, Year) , 1953	MD Cou	place (State or Fo ntry)	
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation						10d. Inside City Li	mits
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	ith ti	Director	10e. Street and Number			10f. Zip C					of What Cou		
	ath v	rai	1715 Aberdeen Road		1	2123					d Stat		
	eb m	by Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decede If Yes, specif	ent of Hispan fy Cuban, Me	iic Origin? (exican, Pue	Specify Yes or No orto Rican, etc.)	- 14.	Race - Ameri Black, White,		
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21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notilised at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Giv	edent's Usual e kind of work	done during	most of w	orking		of Business/Ir ructio:		
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<u>la</u>	should to nd Ment marked umatic e	2	Melvin Charles Kr	eisel			Sn	iriey	Margare	t Piei	rer		
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ā,	f He item		20a. Method of Disposition		20b. Place of Disp	osition (Name	e of ner place)	1	Oct 13	20c. Locati	ion - City or T	own, State	
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Baltimore,	permit. Pages 1 and Depertment of Heali Important: If item 2 any Injury or other page.		21. Signature of Funeral Service Licen		0880				neral Alt			140	
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760,	Physician /Medical Examiner parish: transit pa	cal Examiner	disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): a consequence of):				VIOCUTUI	21000			
P.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	23c. If yes, outcome of the composition of the comp	2 ☐ Fetal death 3 time of death 5	□Ectopic pre □ Other (spe	ocify)	Part I.	23e. Did t		Date of delive Month contribute to	rery Day Year the cause of death	
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	611		30. Name and address of person who		eath (Item 23a) (Typ	e, Print)			Baltimo				
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		<u> </u>	•					
	Regist		OCT 1 5 200	Herm	& Ap	ule							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death	Reg. No.2 0 0 4 3 2 7 4 0
	Physic	an	Decedent's Name (First, Middle, Last)	1/	2. Date of Deeth Month Day Year 3. Time of Death
-	/Medi		CHARLOTTE LOUISE	KIEL	Month Day Year S:20 PM
	Examir	ier	4a Facility Name (If not institution, give street end number)	4b. City, Town, or Lo	0 11:
-	Funcaci		5. Social Security Number 9 6. Sex , Age (In yrs. last bi	irthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Funeral Director		230-05-0914 1 M 2 M F 83	Yrs. Months Days Hours Min.	(Month, Day, Year) 7 ~ 4 - 21 MARYLAND
	laryland show		10a. State 10b. County 10c. City, Tow	vn or Location	10d. Inside City Limits
	the Man 28a-f sh	ģ	MD Ballimore	BALTIMORE	1 □ Yes 2 KNo
	th with the Maryle 23s or 28s-f sho	Funeral Director	10e. Street and Number 1808 Eastdale Rd.	10f. Zip Code 21824.	10g. Citizen of What Country?
	items 2	nera	11. Marital Status 12. Was Decedent Ever in U,S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	scify Yes or No- 14. Race - American Indian,
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic evant, the Medical Examinar must be notified at once.	þ	Armed Forces? 1 Never Married 2 Married 1 Ps 2 No If Yes, 2 No If Yes, 3 We Year or Dates:	1 ☐ Yes 2 No Specify:	Rican, etc.) Black, White, etc. Specify: White.
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Baltimore,	Pages nent of I		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ens of Fairh Constal	10-1504 Rosedale, MD.
3alt	permit. Departn imports any injt		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	TIMORE, MD 21234.
	2011		Kimberly (). Savrotky	FUANS FUDERAL CHAPA	ELXXIO HARFORD RD
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Vital Records,	v require been si should I	ted	Coronary Artery Disease		24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
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	To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by th	edical Certification:	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the basis of examination an and manner stated.		
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	r_{c}	7	30. Name and address of person who complet strause of death (Item 23e)	(Type, Print)	0 1
				000 Franklin Square	Prive Baltimore MD, 21237
	Sta	A.	31. Date filed (Month, Day, Year) 32. Registrar's Sfignafure	lande	ı
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Month **Physician** 10:35 HECTOR SALINAS KALERGUIS 13 10 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE ROSEDALE FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year | tf Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Yrs. N/A78 Director 16,1926 HONDURAS Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2X No Director MD. BALTIMORE **ESSEX** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a 28 HELMSLEY COURT 21221 HONDURAS Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status illed within 72 hours after ☐Yes 2♥ No Yes, Give 1 Never Married 2 Married Specify: HONDURAN 1 XYes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be 2 GONZALOS SALINAS ANNA ROMERO KALERGUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIAS SALINAS/ SON 421 N. BELNORD AVENUE, BALTIMORE, MD. 21224 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages i Department of the Important: If Its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State OAK LAWN CEMETERY 10/16/04 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee L'ILLY & dor LEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARREST CARDIO RESPIRATORY **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner HEMOPTUSIS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed PROSTATE CANCER Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Year jo Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown signed by the detail 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed 1 Yes 2 No certificate Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 7 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Division of 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 T Homicide .⊆ filled 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely dical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) title of c an 55625 d cause of death (Item 23a) (Type, Print) 30. Name and SQUARE DRIVE, BALTIMORE, 9000 FRANKLIN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** IQBAL AKBERALI LANEWALA /Medical October 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Medical Censo 546/56UM REGIONAL Vicomios If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 57 yrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Hours 1**X** M 2□ F Director 192-44-1965 3. 1947 FEB. PAKISTAN Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD WICOMICO Director SALISBURY ty⊡Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2817 PATHFINDER CT. 21801 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2√ No Specify: ģ Specify: ASIAN 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) PHARMACIST permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other i any injury or other traumatic event, III MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AKBAR A. LANEWALA KHATOON POPATIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AFTAB RAMALA/BROTHER-IN-LAW 6359 WHITE COVE DR. SALISBURY, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 10-07-04 LAUREL, MD MD. NAT. CEMETERY 22. Name and Address of FacilityFLECK FUNERAL HOME, INC. Sanature of Juneral Service Lid MOBBY 7601 SANDY SPRING RD. LAUREL, MD 20707 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List bely one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PKEUMONIA Physician /Medical Due to (or as a consequence of): Examiner CANCER Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ TAIL URE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2 No 2[] No 1 Yes 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar

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of Vital

Nicholas Ogburn 31. Date filed (Month, Day, Year)

Carroll

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E.

32. Registrar's Signature

10/6/04

Salisbury, MD 21801

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Joseph Linaweaver Francis October 13,2004 8:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Stella Maris If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Months Hours Min 11XIM 2□ F Yrs. 14,1948 Director 212-54-8357 55 Mary land Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show traumatic avant, the Medical Exercitres results at a Essex 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21221 357 Leeanne Road or Items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married ⊠Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 1967-73 þ Specify 3 ☐ Widowed 4 ☐ Divorced natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Pages 1 and 2 should be filed v nent of Health and Mental Hygie ant: If item 27 Is marked othar t Steamfitter Local 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Loy Ison Linaweaver Mary E. Klosterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or othar trau once. Evelyn Ann Linaweaver/Wife 357 Leeanne Road Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 10/16/2004 Middle River, MD 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Lice 7922 Wise Ave. Dundalk, Maryland art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Tres mas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 🗆 No 1 Yes 2 X No Division of Vital the Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify Stella Horris 2 No Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 27. Magner of ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

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completely f (Check only one) 29b. Signature and title of cerifier 29c. License number 29d. Date signed (Month, Day, Year) un 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print 3509 756=V11 9 ve 31. Date filed (Month, Day, Year) Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year LYMCH JAMES NEAL 10,00 8 9 10 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death V.A. BRECC BALTIMORE - CITY N/A 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 1**X** M 2□ F Days 215-16-1670 Director 80 9/19/1924 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28e-f show other treumatic event, the Medical Examinar must be motified at Director MD BALTIMORE 1 ☐ Yes 2 → No PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1755 WHITE OAK AVE. 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give 1.77777 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If them 27 is marked other then "natural", or item any injury or other treumatic event, the Medical Experience. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 4 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES A. LYNCH FRANCES ANN UNAVAILABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES N. LYNCH, JR. SON 2702 WILDBERGER AVE. BALTIMORE, MD 21234 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 □ Donation 5 □ Other (Specify) METRO CREMATORY, INC. 10/14/2004 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Wrosepsl disease or condition resulting in death) /Medical Due to (or as a consequance of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) by the a Yes 2 No 9☐ Unknown 9 ☐ Unknown n signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dinknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? page Filerillation certificate Atrual 1 ☐ Yes 2 NAO To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Dther: 1 Yes 2 No Certification: To 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10,9,04 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECC D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DCT 1 5 2004 Registrar

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	or 28	Director	10e. Street and Number	^ .		10f. Zip Code			10g. Citizen of What 0	Country?
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10	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No	n U.S. 13. V	Yes, specify Cub	Hispanic Origin? (S) an, Mexican, Puert	o Rican, etc.)	14. Race - Am Black, Wh	
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	Healt Healt tem 2		20a. Method of Disposition	DAUGHTEN	b. Place of Dispos	sition (Name of	DOKALX	Date /	20c. Location - City of	er Town, State
OM	7 1 e 9		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		cemetery, crem 1ETRO CA	atory or other place	110	15-14	BAI TIMA	CE, MARVLAND
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funers Service Licens			Name and Addre		Beaus	JTR. FU	NERAL HOME
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9	tificate ng phys as the	ed	IS SOLVE							
Вох	death certifica e attending ph ed for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnancy	у		23d. Date of de Month	elivery Day Year
P.O. E	the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5□	Other (specify)			MOTAL	Day
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eco	ie law requ has been ge 2 should	Completed	diaselis, hy	pertension.				24a. Was	an 24b. Were a	autopsy findings available completion of cause of
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Zit.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical exampler? 1. □ Yes 2 □ No	Hospital:		Oth	26. Place of Dea			
of	g Phy er this eral d	-	27. Manner of Death	1 Impatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of	3 DOA 28c. Injur	y at		dence 6 Other (Spenow injury occurred	ecity)
ion	Attanding at death. ector: After by the fune	atio	1. ☐ Natural 5 ☐ Pending investigation	(Month, Day 19a)	r) Injury		Yes 2 □ No			
Division of Vital	l or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	kt home, farm, stre ecity)	et, factory, office		28f. Location (. City or Tox	Street and Number or F vn, State)	Rural Route Number,
ш	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying Phy	sician: To the best of my	knowledge, death	occurred at the tir	me, date and place.	and due to the	cause(s) and manner a	s stated
	n 24 h he Fui	Medical	(Check only 2 Medical Exami	ner: On the basis of exam and manner stated.	nination and/or inv	estigation, in my o	ppinion, death occur	red at the time,	date and place, and du	e to the cause(s)
	To the comp	2	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon	
1	18		KE	MP		, ,	3-000)	aroser	8,2004
1	7		20. Name and address of person who co	ompleted cause of death (I	Item 23a) (Type, F	Print) HOSP1T	me of	RAFTI	MORE	
1	Sta	te	31. Date filed (Month, Day, Year) 0CT 1 5 2004		gnature	porks		131711	1-00-100	
	Registr	ar	UCI 1 5 2004							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year _Physician Ronald Frederick Lamcke October 14 2004 9:50A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown - Dorsey Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1⊠ M 2□ F Yrs. 214-01-8116 91 Director 31,1912 Oregon Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show id 2 should be filed within 72 hours after death with the Maryla. Ith and Mantal Hygiene. 22 is marked other then "natural", or items 23a or 28a-f show Yzz is marked other then "natural", or litems 23a or 28a-f show traumatic event, its Macilcal Exercises main be multipled. 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 719 Maiden Choice Lane; HR535 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Frederick Lamcke Emily Marie Hesselmeyer Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health i Maude E. Lamcke (Wife) 719 Maiden Choice Lane; HR535 Catonsville, MD 21228 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If eny injury or once. Balto./Wash. Crematory10/19/04 4 Donation 5 Other (Specify) Laurel, Maryland 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee M00869 1630 Edmondson Avenue Catonsville, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final Uro Sepsis **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy perform 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient Other: AV Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Attending Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 ho To the Fune completely fi the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ND Name and address of person who completed cause of death (Item 23a) (Type, Print) (atansville (and LIZIS Norder 101Ce 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar OCT 1 5 2004

DHMH 17 Rev 1/2001

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			For State	State of Man		anment of F rtificate of I			0001	(") (") "" ! ")
			Registrar 1. Decedent's Name (First, Middle, La	st)		rincate or i	Death	2. Date of Deat	g. No.	3. Time of Death
	Physici	an						Month	Day Yee	r
	/Medic		Madeleine Mary I 4a. Fecility Name (If not institution, giv			4h City Town o	Location of Death	October	12 200 4c. County of De	
	Examin	ier		alth Care					N/A	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (1	n yrs. last birthday)	Do I h m	If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign Country)
	Director		216-05-6756	□M 20XF	79 Yrs.	Months Days	Hours Min.	Dec. 12	, 1914 M	aryland
	pu ,		Usual Residence of Decedent	14	On City Towards					101 Line Challenia
	anyla shov	_	10a. State 10b. County		0c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	he M	Director	MD Balti	more		Arbuti	1S		3 02 110	
	death with the Maryland ims 23a or 28a-f show rittest ke tadiffed at	늅	10e. Street and Number			10f. Zip Code			og. Citizen of What	
	eath	Funeral	5547 Oakland Roa	12. Was Decedent Eve	ar in U.S. 13		227 ispanic Origin? (Sp		nited Sta	tes nencan Indian,
10	ter d	I.	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, W	nite, etc.
036	urs a	by	3	1 □Yes 2 N No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: W	hite
0	72 ho	ted	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation	ina	16b. Kind of Busines	ss/Industry
21	e. en "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of work 1)	"'y		
21	ed wi	Completed	8			Clerk Ty				of Maryland
밀	be fil Ital H Id oth	Be	17. Father's Name (First, Middle, Last				18. Mother's Name			
<u> </u>	Mer J Mer narke	P.	James Joseph Mur		405.44-10			Regina		7-0-4-1
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Exarch must be tradified at 000s.		19a. Informant's Name/Relationship (Robert Lidston	Son					City or Town, State	111-
ō,	1 an Heat Heat		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	1		ille, MD 20c. Location - City	
ΘĽ	ages ant of it: If It		XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		_	natory or other place hedral	10.1	. 2007	D - 1 - 1	
量	artme ortan injur		21. Signature of Funeral Service Lice	man d		emetery 2. Name and Addre		6-2004	Baltimor ral Home,	Tno
ä	permij Depar Impor any ir once.		MULLINON	1(VX D)-1	13	28 Sulpho	r Spring	Rd. Ar	otuus, MD	21227
			rart1. Enter the disease, or com shock, or heart failure. List only	plications that caused th						Approximate Interval Between
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	/Medical		resulting in death)	aDue to (or as a c						racys
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557	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of):					,
P	be executed ician and burial-transi	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
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687	certificate Iding phys	dlc		_ d						
J xog	certif nding use a	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of d	leliverv
7 8	death a atte	hysician/Medl	in the past 12 months? 1 □ Yes 2 🗷 No	1⊡Live birth 2 [4⊡Pregnant at tin		□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
0	t the by the	hys	9 Unknown	9□ Unknown						
S, P	w requires that the death certificate been signed by the attending phys should be detached for use as the	by P	Part II. Other significant conditions	contributing to death but r	not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob		to the cause of death?
ord C	equire en si ould b	bed	Coronary Arker	y Disease.				1 □ Ye	s 2 No 3	Probably 4 SUnknown
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± #	The law ate has b page 2 sl	Соп						perform 1 ☐ Yes 2	ned? death	? es 2⊠ No
Mital Records,	sician: The law centificate has b irector, page 2 s	Be (25. Was case referred to medical examiner?	11			26. Place of Deat	h (Check only on	9)	
, 5	ding Physician: n. After this certific funeral director,	은	1 ☐ Yes 2 🛣 No		2 ☐ ER/Outpatie	-	4 Nursing no		nce 6 Other (Si	pecify)
2 6	ding f	lon	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	(ear) Injury	Wor	yat k? Yes 2 □ No	20d. Describe no	w injury occurred	
Division	death death ctor: y the	ertifications	3 Suicide 6 Could not b		- At home, farm, st			28f. Location (St.	reet and Number or	Rural Route Number,
Z A	after Dire	erti	4 Homicide determined	28e. Place of Injury building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town		
5 _	spita hours meral y filled	alC		hysician: To the best of r						
7	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical	(Check only 2 Medical Exa	miner: On the basis of example and manner state		ivestigation, in my o	pinion, death occur	red at the time, da	ate and place, and d	ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	e number	25	d. Date signed (Mo	nth, Day, Year)
	1		Molamme	d MD		7171	001	0	clober 12	,2004
	り		30. Name and address of person who	·			4	1	. ()	
	C+	ate	Nareesa Mohamm 31. Date filed (Month, Day, Year)	32. Registrar's			more N	ID 2122		
	Regist		OCT 1 5 2004	Benera		mel				

DHMH 17 Rev 1/2001

CIDSTON, MADELEINS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOAN MACNAUGHTON Month Day Year OCTOBER /Medical 2004 8. P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SUBURBAN HOSPITAL MONTGOMERY 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🖳 F 74 Director Yrs 131-22-3497 JAN. 2. 1930 NEW YORK Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location or 28e-f ahow 10d. Inside City Limits Examiner must be notified at Director MD MONTGOMERY BETHESDA 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 230 7111 THOMAS BRANCH DR. death v 20817 Funeral itams 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. and If item 27 Is marked other than "natural; or ital ury or other traumatic event, IIIs Muchal Externing ury or other traumatic event, IIIs Muchal Externing Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 □ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SERVICE COORDINATOR DEPT. OF TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ PASQUAL GENOVA KATHLEEN MCNAMARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRYCE MACNAUGHTON/SON 7111 THOMAS BRANCH DR. BETHESDA, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or ` 4 ☐ Donation 5 ☐ Other (Specify) BALT.-WASH. CREMATORY 10/14/04 LAUREL, MD Signature J Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING RD. LAUREL, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear taure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC SQUAMOUS CELL CARCINOMA OF CERVIC YEAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should Be Completed 1 ☐ Yes No No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No certificate has autonsy perform Vital 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2√2 No his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nten D22775 San MI OCTOBER 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. BUN, M.D. 8600 OLD GEORGETOWN RD. BETHESDA, MD 20814 32. Registrar's Signatura 31. Date filed (Month, Day, Year) State OCT 1 5 2004 Registrar

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) **Physician** Angelo J. Mannone /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis Loch Raven Balitmore If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 1 M 2□ F Months Days Hours 90 Yrs. 218-10-7025 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b Count Director Baltimore N/A 10e. Street and Number 10f. Zip Code

Re	g. No.				3 2	1	. 1	
2. Date of Deatl			1	1.0	3. Time	of	Dea	th
Month	Day		Year					М
October	15,	20	04		9:50	ar	n_	M
	4c. C	ounty	of Dear	th				
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 Date of Birth (Month, Day, 	Year)		9. Bird	thpi	ace (Stat	e o	r Fo	reigr
Oct 4, 1	914		Mar	·y]	and			
				10	od. Inside	Cit	y Li	mits
					1 □ Y	es	25	No
10	g. Citize	n of V	Vhat Co	oun	try?			

United States

14. Race - American Indian.

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Nidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Venetian Blinds College (1-4or 5+) Elementary/Secondary (0-12) Janitor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Del Brocco

21212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Christina Clapers/Sister 1 Dunhaven Place, Apt. TC, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Oct 19 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD * 4 □Donation 5 □ Other (Specify) Most Holy Redeemer 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives M0086

Physician /Medical Examiner

use as the burial-transit

nding physician

Box 68760 cartificate be

P.O. I

Records,

Division of Vital Hospitel or Attending Physicien: Examine

Physician/Medical

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Completed

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Certification:

Medical

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Funeral

Director

28a-f show

Items 23a

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treumatic event, the Medical Examiner must be notified at

by Funeral

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

5610 York Road

Mannone

Samuel

23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused the death. Do not enter the m ly one cause on each line.	ode of dying, such as cardiac or respiratory arrest
Immediate Cause (Final disease or condition resulting in death)	a. LAN YNGENC Due to (or as a consequence of):	CANCER
Sequentially list conditions,	b	

Approximate Interval Between Onset and Death

Vear

Due to (or as a consequence of):

8717 Green Pastures Drive

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

☐Yes 2☐No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Trine FIBNICLATION 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Patural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 THomicide

29a. Certifier (Check only one)

25. Was case referred to medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 00061765 29d. Date signed (Month, Day, Year)

OCTOBER 15 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUCH RAUFY DLUD POS#303 BALTIMONE MA EVENETE OUTHWOO

After

24 hours after death. 9 Funerel Director: A

within 2 the

Registrar

31. Date filed (Month, Day, Year) OCT 1 5 2004 32. Registrar's Signature

04-06418 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kenneth Mulden State of Maryland / Department of Health and Mental Hygiene For Amend Item 1&Unpend Item 23a&2/ per me G836 10-20-04 tas
Registrar Certificate of Death Red. No. Reg. No. Kenneth Alfred Moulden Jr. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Mou Kenneth October 05, 2004 0103A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F December 22,196B 216-88-0346 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. It and Mental Hygiene. ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be truffled at 1 Nes 2 No **Funeral Director** Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 43 RD 503 51515 Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 19ck Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber SELF permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. Fulton Kennoth A. Moulden Eliza ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowleys Lane Balthone MD 2120/ 5302 K. Fulton onnie Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion (em Octobe 13, 2014 Lansburg 21. Signature of Fyner II Service Licens e 22. Name and Address of Facility Funeral Service, P.A. Han P. Cluse Funeral Service, P.A. St. Baltimore 2591-10515 am. 709 Tessier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Occlusive Thrombus Of Left Anterior Descending Artery **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Minknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 1 Xes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital within 24 hours a To the Funeral E Hospital

29b. Signature and title of certifier 101

29c. License number O.C.M.E.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year, October 05, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 RUBIO, MD ANA

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 1 5 2004

(Check only one)

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #8 PER FH G836 10722/04 of Death 2. Date of Death 3. Time of Death Day Year **Physician** :15P. M. EYMTHIA IORGAN OTTO BERIS 4006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year of Under 24 Hrs. SAND DOMAR WAY GALTIMORE 19202 5. Social Security Number 8. Date of Birth (Month, (1984, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) Months Days 1 M 20 F Hours Min Director A16-54-1058 Usual Residence of Decedent MERCY the Maryland 10b. County 10a. State 10c. City, Town or Location 27 is markad other than "natural", or itams 23a or 28a-f show traumatic avant, the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo BELLIMONE melber I. HASS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with AR J.S.A. 19802 21230 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene. Is markad othar than "natural", or Ital 1 ☐ Yes 2 No 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: à 3 Widowed 4 Divorced Specify: Willew Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SIKP HomeMAKER AT Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis SHULTZ WALIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traun once. ROCERT S 12805 SAN DOLLAR WAY
ce of Disposition (Name of Date 220HJ JARY LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - ity or Town, State 20a. Method of Disposition Pages 1 tment of I 000 23 1XBurial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) KO'Z DALI GARDING OF FAITH 3604Service Licensee 22. Name and Address of Facility = N& MORILS EXANS HARFORD ROPE PARK 8800 HARFORD ROPE PARK 21234 1ARY LAW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician KEUAL AILUKE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner URETERAL OBSTRUCTION ILATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner GASTRIC ADENS CARCINOMA 45 DAYS certificate be executed signed by the attending physician and debetached for use as the burial-transit TASTATIL resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ů 1 ☐ Yes ZXNo 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification After or Attanding Natural 5 Pending investigation Injury within 24 hours after death. To tha Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 29a. Certifier 🌃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Welliam P. M. Acure MD 016801 00,000 RIH 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Mª GUIRE, MT) VILLIAM P. 9103 TRANKUN SOLIAR TOR. ,32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2004 0CTRegistrar

DHMH 17 Rev 1/200

State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 3115PM 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Buttimore CLOUIS If Under 24 Hrs. 8. Date of Birth If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 18 Days Months 12M 20 F 220-64-800. Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location nside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 806 or Items 23a Funeral t of Hispanic Origin? (Specify Yes or No Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 o Specify: Ď 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Ear. 17. Father's Name (First, Middle, Last) Be elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20c. Location - City or Town, State thod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, decomplications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 ANO 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Tes 2 NO Certification: To 1 Impatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner et Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 29a. Certifier 🗠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Keith J. Martin 04 - 6540Unpend Item 2 State of Maryland & Department of Health and Mental Hygiene AKG Certificate of Death Reg. No. UNK 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Keith James Martin 8:42 A October 10, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11X M 2 □ F 214-96-4676 Yrs Director 40 Nov 21, Maryland 1963 Usual Residence of Decedent with the Maryland item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, It a Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Hampstead 1 ☐ Yes 2 No Director Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 18231 Marshall Mill Road 21074 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. a filed within 72 hours after it Hygiene. other than "natural", or Ite 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Never Married 2 ☑ Married 0. Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Network Systems Financial Analyst 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hight: If item 27 Is marked oth James Edward Martin Beatrice DeVeas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly J. Martin, wife 18231 Marshall Mill Road, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. Carroll Cremations 10/12/2004 4 □Donation 5 □ Other (Specify) Hampstead, MD 21. Signature - Fureral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician a Cardiac Arrythmia Due To Subendocardial Fibrosis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Cher (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No I or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No 10 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 11, 2004 person who completed cause of death (Item 23a) (Type, Print) Southery, MD 111 Penn Street, Baltimore, Maryland 21201 Pamela E. 31. Date filed (Month, Day, Year) 32. ⊈egistrar's Signature State Registrar

sse Type or Print in Black Indelible Ink Tonsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 10:40 9 M Edward John Myers 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frank In Square Hospital Center Rosedale
If Under 1 Year | If Under 24 Hrs. timore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 XM 2 ☐ F Months Hours Yrs. 217-22-5715 Dec. 17, 1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3824 Mary Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th. Grade Butcher Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles F. Myers Philomena Neun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Myers/Wife Mary Avenue Baltimore MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 10/11/2004 Elkridge MD 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licensee 21206 6415 Belair Road Baltimore 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meumonia Due to (or as a consequence of): Muelofibrosis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Cher (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

21215-0036

Baltimore, Maryland

the Maryland 28a-f ahow

> State Registrar

DHMH 17 Rev 1/2001

iare Drive

MUD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tamar Smith

1 5 2004

31. Date filed (Month, Day, Year)

			For State Registrar	State of Mar		artment of rtificate o		nd Mental Hyg	giene Reg. No.	004	32756
	Physici /Medic Examir	cal .	Decedent's Name (First, Middle, Last) Bertha Mary McHo 4a. Facility Name (If not institution, give s Lorien Riverside	ou1		4b. City, Town	, or Location of I	2. Date of Dea Month Octobe	r 9,	Year 2004 ounty of Death	3. Time of Death 6:00 P M
	. Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Yes Months Day	ar If Under 24	Hrs. 8. Date of Birth Min. (Month, Day 4/16/1	h	9. Birthp	olace (State or Foreign htry) Jersey
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	1 and Health em 27 ther tr		19a. Informant's Name/Relationship (Ty, Lawrence McHoul/S	Son	1404	4 Hilsch	er Ct.	or Rural Route Numbe Abingdon,	Mary1		009
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		1	GIIIOVAI IIOIII OLALG		VN 2. Na <i>m</i> e and Add	dress of Facility	10/12/04	Marr ppel	iottsvi Funeral	lle, MD Home Inc.
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s 1 an if Heal item 2		20a. Method of Disposition		b. Place of Disp	osition (Name of matory or other place	201	Date U	20c. Location	- City or To	wn, State
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Deficiency of the permit. Pages 1 a Department of Healington of Healington of the any injury or other once.		21. Signature/of Funeral Service Ligen	- 1.3	rlington	2. Name and Addre	ss of Facility F I	eck funei	al Hay	no Inc	/ P
permit. Pag Department Important: 3 any injury o	16	De Mila	touvent		601 Sandi		3	rel. M	0 207	۸٦
a. 45		23a. Pert1. Enter the disease, or comp	lications that caused the d						0 20 1	Approximate
		shock, or heart failure. List only inmediate Cause (Final	one cause on each line.	1. 1.	n. (. ,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a MEIUSTO	TIC LL	ing can	LY				
Examiner			Due to (or as a con	sequence or):	water 1	Inc.	DICARSA			
	<u>~</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con-	sequence of):	uctive i	ung i	DIDEUSE.			
ted	Examiner	Cause (Disease or injury	, , , , , , , , , , , , , , , , , , , ,	,						
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death certificate be executed eathoring physicien and dor use as the burial-transit			d							
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attendin for use	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3	□Ectopic pregnancy □ Other (specify)				fonth	Day Year
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hat the deby	P	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderiving cause giv	en in Part I.	23e. Did tob	acco use co	ntribute to th	ne cause of death?
vical necolds, sician: The law requires to certificate has been signed rector, page 2 should be or	by		•		, , , , , , , , , , , , , , , , , , , ,		1 Z Ye	s 2 🗆 No	3 □ Prob	ably 4 🗆 Unknown
require hould	Completed									
law las t	n du						24a. Was ar autops	246	. Were autor prior to cor	psy findings available apletion of cause of
	Co						perform	Z No	death? 1 ☐ Yes	2 🗆 No
sian: ertific	Be	25. Was case referred to medical examiner?					th (Check only one	9)		
Physician: The lavinis certificate has	To	1 ☐ Yes 2 🗗 No	Hospital: 1 Inpatient			4 🗀 Nul Sing H	ome 5 Reside	nce 6 🗆 O	ther (Specify	()
I or Attending Phy after death. Director: After this in by the funeral d		27. Manper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occu	urred	
endingsth.	atle	2 Accident investigation			M 1 🗆	Yes 2 ☐ No				
r Att	ţ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office		28f. Location (Sti City or Town		nber or Rura	l Route Number,
rs aflo	Certification:									
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I		29a. Certifier 1 Certifying Ph	ysicien: To the best of my niner: On the basis of exam	knowledge, dea	th occurred at the tin	ne, date and place	, and due to the ca	use(s) and n	nanner as st	ated.
the F the F uplete	Medical	one)	and manner stated							
with To	2	29b. Signature and title of certifier	1 theres.	0010 - 14	29c. Licens	e number	_	d. Date sign		
, ,	0	- Menne &	· 41973 - Con	Juen 10	028	079)ct. 8		
/		30. Name and address of person who	completed cause of death (Item 23a) (Type		2	.1	14	-2 . 2	21042 Cott City Mu
		Francine High	s-Shipma	1, N.O	5082	- Dorsei	1 Hall C	12 103	21110	LOTT CITY MU
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature A	north	_	J			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 10 6 2004 1:45p. Plunkett Sarah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perring Parkway Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 □ F Yrs. Director 20 37 MD 213-32-7692 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show f Health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28a-1 shov other traumatic event, the Medical Examinat must be notitied at 1 ☐ Yes 2 XNo Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 1801 Wentworth 21234 Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: 3 XWidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Technican 4yrs+ 12th grade Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Calvin Holt Matilda Walkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Warner Jr.-Nephew 11819 Brandon Oaks, San Antonio, Tx 78253 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō = 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 permit. Page Department o Important: if eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 10/12/04 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. Ime 2 hamper 4300 Wabash Ave. March F.H. West 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -UPG Privsician MASS SIX MUNTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Cliesase of it jury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. detached 9☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, pe DEMERTIA 1 Yes 2 No 3 Probably 4 Munknown page 2 should Be Completed 24a. Was an autopsy performed? 1 Yes 2 No ERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident Injury 5 Pending 1 TYes 2 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0061765 OCTOBER 11 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 170B #303 BALTIMORE MD 21239 SGUI LOCHRAVEN BLUD FBENEZER QUAINOU 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State	State of Mary	•			lental Hyg	iene	
			Registrar 1. Decedent's Name (First, Middle, La	nel.	Ce	rtificate of	Death		ag. No.	<u> </u>
	Physic	an	1. Decedent's Name (First, Middle, La	Ć .	Paris	11		2. Date of Deat Month	Day Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution, giv	ugene	rowe		r Location of Death	10	4c. County of Dea	8:157. M
1	Examir	ner	10541 Cata	ida a Rd		Pag Lan	cocation of Death		BALTIN	
	Euporal		5. Social Security Number 6.5	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Funeral Director			M 2□F	8/ Yrs.	Months Days	Hours Min.	(Month, Day,		thplace (State or Foreign ountry) RUSKO
	D.		Usual Residence of Decedent	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·		77.70	25 1706	JAGONG C
	inylar show		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f s	cto	Ms Balti	MORE	Ca	Key SVi	lle			1 ☐ Yes 2 No
	or 2	Dire	10e. Street and Number	. 01		10f. Zip Code	1030	10	Og. Citizen of What C	ountry?
	s 23e	Funeral Director	10556 Cater	age Kol.		\sim	1030		UDH	
	ter dea	une	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	ours after death with the Marylan ral', or Items 23e or 28a-f show Examiner must be notified at	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 I IIYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	14:40
21215-0036	172 hours after death with the Maryland "natural", or Items 23e or 28a-f show idical Examiner must be notified at		15. Decedent's E	ducation		dent's Usual Occup			16b. Kind of Business	/Industry
7.2	within 73 ene. then "n	ple	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind ol work done i DO NOT use retired	during most of worki d)	ing	0	
21	d with giene.	Completed	12	College (1 401 04)	Bec	KeR.			Keal (?	state.
	be filed within 72 ho ital Hygiene. Id other then "natur event, The Modical	Be (17. Father's Name (First, Middle, Last	0 11			18. Mother's Name	(First, Middle, M	Maiden Surname)	
<u>Jai</u>		To 1	Lawrence	Powell			Vera	Pike	4	
Maryland	d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship	11 . 1	19b. Maili	ng Address (Street	and Number or Rura	al Route Number	City or Town, State,	Zip Code) 21030
-	s 1 and f Health item 27 other tr		Judy H. Pow		1053	the same of the sa	ERIDGE	nd., L	ockey SVI	The MD
Baltimore	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3	I	Ob. Place of Dispo cemetery, cre	matory or other place	2		20c. Location - City of	
ţ	tmen tmen tent: jury		`4 ☐ Donation 5 ☐ Other (Speci	s) E	VANS FUL	SERAL CHAP	EL- 10-1		CREST HI	
Bal	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	nsee	2	2. Name and Addres				UM, MD 21093
			23a Part 1 Enter the disease or cour	Alignothat caused the	death Do not on	ACEFUL AL				Approximate
			23a. Part1. Enter the diseste, or conshock, or heart failure. List only Immediate Cause (Final	or cause o each line.	1101).00	10 10 110 110 110 110 110 110 110 110 1	1 L L	a si -	,	Interval Between Onset 2nd Death
	Physician /Medical		disease or condition resulting in death)	a COVI	MUMIC	2 of	0/000	WY		MUNDAUM
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	uted id ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	С.						
0,	an ar		resulting in death) Last	Due to (or as a coa	nsequence of):					
8760	cate be executed obysician and the burial-transit	dical		_ d.						
9		Med	IF FEMALE:							
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live birth 2	Fetal death 3	☐Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
0.	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at time 9∏Unknown	of death 5[Other (specify)				52,
Δ.	The law requires that the death certifit that been signed by the attending to age 2 should be detached for use as		Part II. Other significant conditions	contributing to death but no	t resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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Re	The lar ate has page 2	Completed						autopsy	prior to death?	utopsy findings available completion of cause of
Vital		Ç	25. Was case referred to predical				26. Place of Death		Trofo 1 ☐ Yes	2 □ No
>	Physicien: this certific ral director,	O B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth			nce 6 Other (Spe	voifu)
ı of		n:T	27. Mann of Death	28a. Date of Injury (Month, Day Yea	28b. Time o		y at	28d. Describe ho		Olly
io	E . Z 5	atlo	1 1 atural 5 ☐ Pending 2 ☐ Accident investigation	n	ar, inquiry		Yes 2 □ No			
Division	of or Attend after death Director: ,	Certification;	3 ☐ Suicide 6 ☐ Could no 8 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, st	reet, factory, office	:	28f. Location (Str. City or Town,	eet and Number or R . State)	ural Route Number,
	itel o Irs aft rel Di	Cer			,,					
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b	ical	(Check only 2 Medical Exa	nysician: To the best of my miner: On the basis of exa-	y knowledge, deat mination and/or in	h occurred at the tin	ne, date and place, a	and due to the ca	use(s) and manner a	s stated.
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifies	and manner stated.		29c. Licensi				
	7 × 00	_	200. Signature and title of certifier	Maria Ak	7	MI II	2111	29	d. Date signed (Mon) I
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	511		30. Name and address of person who	completed cause of death	III IIII ZJAJ (Typa,	MININA	KN B	the M	(N /12)	10
	Sta	ate:	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature /	y your	14 20	110, 14	HAIM	O
	Regist		OCT 1 5 200	fre was	for ,	Aparts!				

Donald & Powell

		•	1 - For State of Maryland	Department of Health and Me Certificate of Death	ental Hygiene
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) EITEN 4a. Facility Name (If not institution, give street and number)	0 61:	2. Date of Death Month Day Year OY/O M 4c. County of Death
	Funeral Director	ler	5. Social Security Number 6. Sex 7. Age (In yrs. last 213-30-7474 1 M 2007 69	birthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Year) FIRM 31, 1935 9. Birthplace (State or Foreign Country) MD
	e Maryland ta-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MA BALTIMORE 10c. City, To	own or Location White Marsh	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Macified Examiner must be notified at	Funeral Director	10e. Street and Number 10032 T ChaB22. L.M. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code 2 \ 2 \ 3 \ 0 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	10g. Citizen of What Country? U.S.A ffy Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc.
5-0036	72 hours afte natural', or l	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No Specify: 6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Specify: LuhiTe
1d 2121	e filed within at Hygiene. other than "	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	SUPERVISOR	U.S.F.4G.
Maryland	2 should be and Mental is marked o aumatic eve	To E	7 (GAK SMOLINSK) 19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural I	
_	Pages 1 and 2 nent of Health int: If Itam 27 i iry or other tre		Burial 2 Cremation 3 Removal from State	3 206 WALUT AVE, 6 of Disposition (Name of patery, crematory or other place) D LAWN CEM.	te 20c. Location - City or Town, State
Baltimore,	pernit. Pages 1 a Department of Hea Important: If Itam any injury or otha		21. Mature of Funeral Service Licensee Aul. M. Stella	22. Name and Address of Facility	BAHE, MO 21234
	Fnysician /Medical		23a. Party. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		respiratory arrest, Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, kearing to him rediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the control	chroid hemo	crhage 14 days
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Ξ	(0	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/	26. Place of Death (i Outpatient 3 DOA Other: 4 Nursing Home	Check only one) 3 5 ☐ Residence 6 ☐ Other (Specify)
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	To th within To th compl	Me	29b. Signature and Jitle of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	,)		1/48 /1/107/L	~ KES-000	1 October 11,2004
	Sta	te	30. Name and address of person who som pleted cause of death (Item 23) Matt McC. The Johns 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Hoplans Hospital 60	ON Wolfe Bullinare MOZIZ87
	Regist	-	OCT 1 5 2004 Same	5 Some	

			State of Maryland / Department of Health and Mental Hygiene
		_	1 - State Registrar Certificate of Death Reg. No. 11 32762
	° Physicia	an	1. Decedents Name (First, Middle, Last) Richard Emil Peder Ser 2. Date of Death Month Day Year 10 08 2004 8.320M
	/Medic Examin		4a. Façility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		<u> </u>	BALTIMORE VAMEDICALCTE BALTIMORE N/A
	Funeral		5. Social Security Number 217-09-2177 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. Months Days Hours Min. DF: C. 6. 1914 9. Birthplace (State or Foreign Country) MRYTAND
	Director		217-09-2177 89 Yrs. DEC. 6,1914 MARYLAND Usual Residence of Decedent
	ryland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	ne Ma 8a-f s	ecto	MD. N/A BALTIMORE ¹ÃYes 2□No
	with ti	Dir	10e. Street and Number 1627 EASTERN AVENUE APT. 304 10f. Zip Code 10g. Citizen of What Country? U.S.A.
	death ms 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
9	within 72 hours after death with the Maryland ene. than "natural", or Itams 23s or 28s-f show fre Madical Examinet must be mulified at	/ Fui	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No □ □ □ □ Yes 2 □ No □ □ □ □ Specify: Specify: Specify:
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ž	should nd Men marka imaric	은	RICHARD EMIL PEDERSEN, SR. CHRISTINA BLUMBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	nd 2 shoulth and 27 is m		NANCY LEWANDOWSKI/DAUGHTER 322 BYNUM RIDGE RD., FOREST HILL, MD. 21050
ore,	es 1 an of Heal fitam 2 r other		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of commetery, crematory or other place) 20c. Location - City or Town, State
Ē	Pages ment of tant: If it		CROWNSVILLE V.A. CEM 10/12/04 CROWNSVILLE, MD.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at anongo.		21. Signature of Funeral Service Licensee 22. Name and Address of Eaching. 22. Name and Address of Eaching. ELILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE. BALTIMORE, MD 21231
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) April CV or the Apri
	/Medical Examiner		resulting in death) aue to (or as a consequence of):
	Examiner	L	Sequentially list conditions, if a y, leading to it mediate cause. Enter Underlying
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.
oʻ	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):
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Box 68	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
	0 0 0	ıclaı	in the past 12 months? 1
P.0	The law requires that the ate has been signed by the bage 2 should be detache	Phys	9 Unknown Part Where significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ds,	uires tha signed d be de	d by	Party Other significant conditions contributing to death but not resulting in the discerning cause given in Party. 1 Yes 2 No 3 Probably 4 Donknown
Record	w requir	ompleted	Cancaba High Tally 24a. Was an 24b. Were autopsy findings available
	The lav	mo:	autopsy performed? death? 1 Yes 2 20 No
Vital	yaician: Th is certificate director, pag	BeC	25. Was case referred to medical an examiner? 26. Place of Death (Check only one)
of	Phya this	P :	1 Yes 2 No
on	ftei	tlon	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Solve 1 Injury 2b. Time of Solve 1 Injury 2b. Time of Solve 1 Injury 2b. Time of Solve 1 Injury 2b. Time
Division	r Attendi er death. ractor: A by the fi	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the comple	Me	29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year)
)			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Jackson MD 10NOLLENC Street BAH i more MD 21201
	4+1		30. Name and address the person who completed cause of death (Item 23a) (Type, Print) David Juckson M) JUNI LEAN Street BAH i mure M) 21201
	Sta	ite	31. Date filed (Month, Day, Year)
4	Registi	-	OCT 1 5 2004 Beren & Species
DH	MH 17 Rev 1/2	001	7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 1510 october 2004 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, 4c. County of Death Examiner heJohns Kins 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** ^{Yea}1935 1□M 2 F Months Days Hours Min. Virginia 216-32-6614 68 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ ¥No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1614 C Swallow Crest Drive 21040 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) A Hygiene. Airplane Parts Elementary/Secondary (0-12) College (1-4or 5+) Machinist Manufacturer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Raby James Bratton Elsie Stella Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Allender Road, White Marsh, MD 21162 Sandra L. Howdyshell / Daughter Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State ö Department of Important: If any injury or good. 10--04Bel Air, Maryland Mt. Zion U.M. Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McComas Funeral Home, P.A. Mark T. 1317 Cokesbury Road, Abingdon, MD 21009 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic Physician Dissection HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown à signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 22 No 24a. Was an autopsy performed? Yes 2 \(\square\) No 1 Yes certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 XNatural Injury Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check off) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

			For State Registrar	State of	f Ma	ryland / De	partment e <i>rtificate</i>			•	giene Reg. No.	nl.	20761
•			Decedent's Name (First, Middle	e, Last)						2, Date of De	ath	13.17	3. Time of Death
	Physicia /Medic		Ataul				R	ana	1	Month 0Close	Day	Year 2004	11:50 AM
	Examin	- 2	4a. Facility Name (If not institutio	n, give street and nu	mber)		4b. City, T	own, o	Location of Death		4c. Cou	nty of Death	
	jie			EAUTH CA					IMORE.				
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F		(In yrs. last birthda	Months	Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthp	place (State or Foreign ntry)
	Director		219-33-3383 Usual Residence of Decedent			7.2 Yrs.				08 1	5 32	1 Ir	ndia
	yland		10a. State 10b. County	,		10c. City, Town or	Location					1	10d. Inside City Limits
	a-1s	ctor	MD NA			Baltimo	ore						XXYes 2 □ No
	ith the	Oire	10e. Street and Number				10f. Zip 0	Code			10g. Citizen	of What Cour	ntry?
	ath w	Funerai Director	1712 West Lo						.223		Paki		
	er de Items	nne	11. Marital Status	12. Was Dec	orces?	ver in U.S. 1	Was Decede If Yes, specif	nt of H y Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. F	łace - Americ Ilack, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced		ve XXV	0	1 ☐ Yes 2	No K	Specify:		Spe	cify: Λ α	ian
9	2 hou			nt's Education		16a. De	cedent's Usual	Occup	ation		16b. Kind of	Business/In	
21	thin 7 e.	npie	(Specify only nigne Elementary/Secondary (0-12)	st grade completed) College (life	o. DO NOT use	retired	during most of work d)	ang			
2	be filed within 72 hours after death with the Maryland (at Hyglene.) of other than "natural", or Items 23a or 28a-1 show event, the Medical Examination in the institled at	Completed	5th grade	na		I	actor	λ M				actor	ТУ
Pu	be fill d oth	Be	17. Father's Name (First, Middle,						18. Mother's Nam		Maiden Surr	ame)	
2	d Mer narke	10	Mohammod Yam 19a. Informant's Name/Relations			10h 14c	ilian Addana /	Ctanada	Hameeda		- Citual Ta	Chile 7:-	- C-+1
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If tem 27 is marked oth any injury or other traumatic even once.						0.2307.040		and Number or Rui				
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و	Pages ent of nt: If it		XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 Removal from	State				e Park 10/				
at:	mit. F bartme oortar injut		21. Suradure of Funeral Service		,		22. Name and	Addres	ss of Facility	13/04	Kanda	IISCC	JWIII Ha
ä	Per Per Per Per Per Per Per Per Per Per	-	hanno		Ma		March	F/E	H West ash Ave,	Balti	more.	Md	21215
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	Pnysician		Immediate Cause (Final disease or condition				OCARDI	AL	INFARC	(101)			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a	consequence of):							\$1=1.0.
	LXdiffile).	_	Sequentially list conditions,	b		HEMIC CONSEQUENCE Of J.	CARDI	MC	YOFATHY				YEARS
_	ted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d	(01 45 4	consequence or,							
14	axecu n and al-tra	Exar	that initiated events resulting in death) Last	c	(or as a	consequence of):	·						
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~ 9		Aedi				70*/							
Box	eath certifica attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome o		3 □Ectopic pred	nancv				Date of delive	•
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P 9.	that the de led by the a detached f	Phy	Part II. Other significant conditi	one contributing to a	loath bu	t act reculting in the	undoch ing on	100 000	on in Dort I	22a Did to	abacco uso o	antributa ta ti	ne cause of death?
ds,	Se Ded	d by		NAL FALL		t not resulting at the	onderlying cat	nse Givi	en in Faut I.		obacco use ci ∕es 2□No		
/ H, K		Completed	INFLAMMATOR			A'SEAKE.	-			24a. Was	24	- Was	and finding and labor
) K	sician: The law certificate has b irector, page 2 st	dw	TO ST CAROTO (AS (O))	c7 Back		asemse.				autop perfo	sy rmed?	prior to cor death?	psy findings available mpletion of cause of
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5 >	Physician: this certificaral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No		mpatier	nt 2□ER/Outpat	ient 3□ DOA	Oth	or	ome 5 Resid		Other (Specifi	v)
100	m		27. Manner of Death	28a. Date		The state of the s		c. Injury Worl		28d. Describe h			
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Q ≥	pr At ter c irec irec	Certification:	3 Suicide 6 Could 4 Homicide determ	ained 289, Place	of Inju ling, etc.	ry - At home, farm, . (Specify)	street, factory,	office		28f. Location (5 City or Tox		mber or Rura	l Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in I		00-0-15-	- Di									
3	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the band man	asis of	examination and/or	investigation, i	n my o	ne, date and place, pinion, death occur	red at the time,	cause(s) and date and plac	manner as st e, and due to	tated. the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certific	er _			29c.	License	e number		29d. Date sig	ned (Month,	Day, Year)
	->=0		Nhurty N	1.D MULTAZ	AK	AZMI. MI		P-	17610		0 ctos	SER I	2, 2004
	1		30. Name and address of person	who completed cau			*					*	
_			IMPETAZA KAZA			INES HOL	PITAL 9	100	S. CATON	AVE, B	ALTIMO	RE M	D 21829
	Sta Registr		31. Date filed (Month, Day, Year OCT 1 5 2004	fre as	Registra	r's Signature	oak	,					
	negisti	el ·	UU1 I 3 2004	June 1	-	1 /7							

			1- State of Maryland / Depa Registrar Cert	rtment of Health and Me tificate of Death	ental Hygien Reg. N	2001. 207cm
	Physicia		1. Decedent's Name (First, Middle, Last) DANIEL STACY ROGERS	1	2. Date of Death Month D	2ay Year 14, 2004 6:20A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death		4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 5. Social Security Number 5. Social Security Number 1. MM 2□F 6. Sex 1. MM 2□F 6. Sex 7. Age (In yrs. last birthday) 6. Sex 1. MM 2□F	terminal Davis I Harris I tela	8. Date of Birth (Month, Day, Yea SEPT, 12, 1	9. Birthplace (State or Foreign Country) 7936 TEXAS
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f show any Injury or other treumetic event, Ita Ne Iteal Exartained to the motified at an 2016.	Funeral Director	Armed Forces? If 1 □ Never Married 2 Married 1 □ Yes 2 No 1 □ Yes 6 No 1 □ Yes 6 No		cify Yes or No-	10d. Inside City Limits 1 □ Yes 2 ▼ No Citizen of What Country? 1. S. A. 14. Race - American Indian, Black, White, etc. Specify: 1.14-17-
3 21215-0036	filed within 72 hours Hygiene. Ither than "natural", ont, the Medical Exa	e Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	lent's Usual Occupation kind of work done during most of working DO NOT use retired) I.C. TNFOR HATION	9 0	Kind of Business/Industry CITEO STATE FORAL GOVIT
Maryland	should be tand Mental Is marked o	To Be	LENUS GARMAN	REG/NA g Address (Street and Number or Rural	MILLE	var Tour State Zin Code)
Baltimore, Mar	permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any Injury or other treun <u>once.</u>		SYLVIA M. ROGERS 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	CIDER MILL RO	AD, CAR, 20c. 1,2004 PA	NEY MARKAND Location - City or Town, State RKVILLE, MD
8760,	cate be executed /Medical /Medical Examiner:	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Listage or High) that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death E WEEKS
P.O. Box 6	death certifi e attending id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ 4 □ Pregnant at time of death 5 □	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	es ign			nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 X No 3 □ Probably 4 □Unknown
Records,	e law has b	Completed	CLOSTRIDIUM DEFICILE COLITIS		24a. Was an autopsy performed?	
Division of Vital	ng Physicien: Ater this certific Ineral director.	Certification: To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatien	28c. Injury at 21 Work? M 1 ☐ Yes 2 ☐ No	ne 5 Residence 8d. Describe how in	
Divis	pital or Att urs after d rel Direct			,	City or Town, Sta	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical		n occurred at the time, date and place, at vestigation, in my opinion, death occurre	d at the time, date a	and place, and due to the cause(s) Date signed (Month, Day, Year)
	13	/	A. J. Helory, M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type,	D 17695	Oct	tober 14, 2004
	St Regist	ate rar	ARDAL AH J. HE OL M. D. 76.01 [15] 31. Date filed (Month, Day, Year) 22. Registrar's Signature	LER DRIVE TOWSO	N MARYL	AND 21204

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 748 PM Harry Emerson Rose, Sr. OCTOBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Harford Clin 4 pper Chesoplatie Mark If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 GM 2 □ F 217-24-3583 76 Director 1928 Virgínia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits marked other than "naturel", or Items 23a or 28a-f show matic event, the Medical Examinar must be notified at Bel Air 1 ☐ Yes 2X No Director Harford Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21014 United States 1903 Spruce Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Harried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene steel steel worker 8 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental F Goldie Elizabeth Raynor Lonnie Lee Rose 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tre once. 1903 Spruce Drive, Bel Air, Md. 21014 Mildred C. Rose/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 ☑Other (Specificant ombment Bel Air Mem. Gardens 10/13/2004 Bel Air, Md. 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 West MacPhail Road, Bel Air, Md. 21014 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 ☐ Yes 2 1 No or Attending Physicien: Harry Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 □ DOA Other: 2 1 Xes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No d in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 100/4206 MA DINE 1241 no completed cause of death (Item 23a) (Type, Print) 7018 HOLADIRD AVE expl, MO, DME 31. Date filed (Month, Day, Year) 32_Registrar's Signature State Registrar

			For State Registrar	State of M	Maryland		irtment of H		nd Me		iene _{eg. No} ?	de la company de	32767
	Physicia	an	1. Decedent's Name (First, Middle, Las					-	2	Date of Deat		Year	3. Time of Death
	/Medic	al	Gloria M		eidy					Oct		2004	9:20 P.M.
	Examin	GI	4a. Fecility Name (If not institution, give Howard County Gene			ar	4b. City, Town, or Columb		Death		4c. County		
	Funeral	100	5. Social Security Number 6. Se		Age (In yrs. la		If Under 1 Year	If Under 24	4 Hrs. 8	Date of Birth (Month, Day,		9. Birtho	place (State or Foreign
	Director		417-42-0901	_M 2 ⊠ F	71	Yrs.	Months Days	Hours	Min.	Month, Day, Dec.16,	1932	Ala	bama
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation					1	0d. Inside City Limits
	Aaryla f sho	ō	Maryland Howard										1 ☐ Yes 2 📉 No
	28a-	Director	10e. Street and Number			lumbia	10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	h with		6336 Cedar Lane				21044				USA	A	
	ams 2	Funeral	11. Marital Status	12. Was Deceder Armed Force			Vas Decedent of Hi Yes, specify Cuba	ispanic Origin	n? (Speci Puerto Ri	fy Yes or No-		ce - Americ	
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15	C 2 34	Completed	(Specify only highest grad		r 54)	(Give	kind of work done o OO NOT use retired	turing most o	of working	7			
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Maryland	should be filed within 72 hours after death with the Marylan of Mentai Hygiene, marked othar than "natural", or Itams 23a or 28a-1 show matic event, the Medical Evantinar must be notified at	Be	17. Father's Name (First, Middle, Last) John Miles							First, Middle, M	Maiden Suman	ne)	
₹	should b and Ment marked umatic e	P	19a. Informant's Name/Relationship (7	una Orinti		10h Mailie	g Address (Street a		se Ri		City as Tayra	Ctata Zin	Codel
Ma	2 2 2		Miles Reidy		Son						2 08000		
ē,	ges 1 and 2 t of Health if Itam 27 i		20a. Method of Disposition		20b. Pl	ace of Dispo	Maryval sition (Name of natory or other place		Dat	TITEOE	20c. Location	City or To	own, State
Ê	Pages nent of h ant: If Ita		1 🕅 Burial 2 ☐ Cremation 3 ☐: '4 ☐ Donation 5 ☐ Other (Specify				orial Gar		10/16	/2004 1	Mobile,	A1a1	bama
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	Coupe	7	22	Name and Address Witzke F 5555 Twi	s of Facility uneral n Knol	L Hom L1s R	es, Ind	c iumbia	a, MD	21045
ň	1		3a. Pa . Enter the disease, or comp	lications that caus	ed the death							1	Approximate Interval Between
4	- Pnysician		I mediate Cause (Final isease or condition			Acute	Muscan	dial	Int	antion	7		Nours
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ience of):	Myocan Cardii tes Me	***************************************	1				
		-	Sequentially list conditions,	b. Afha	roscle	eriotec	Cardu	vascu	lar	Visea	esc		years.
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			Pinho	ter Me	Hitras	Te	- T			140-0
o,	The law requires that the death certificate be executed at been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Еха	resulting in death) Last	Due to (or a	as a consequ	ence of):	10	***//***	1/	ic so			jears
8760	ate be physicia the bu	dical		d									
9	entifica ling pl	Med	IF FEMALE:	22- 4									
Вох	eath certific attending p	Physician/Me	in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant	2 🗌 Fetal	death 3□	Ectopic pregnancy Other (specify)				1	ite of delive onth	ery Day Year
o.	t the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		au SE	Otter (specify)						
Α,	res that igned b be deta	by PI	Part II. Other significant conditions co			liting in the ur	nderlying cause give	en in Part I.		23e. Did tob	acco use conf	tribute to th	ne cause of death?
ecords,	w require been sig should b	ed b	Chronic Rena Hypertension	1 Fail	ture				_	1 - 1 1	s 2 🗆 No	3 🗌 Prob	ably 4 Unknown
ecc	e law re has be	Completed	Hypertension	n						24a. Was a	V	prior to cor	psy findings available mpletion of cause of
E B		Con	abdominal	aortic	ancu	nson				perform	ned?	death? 1 🗌 Yes	2 2 N 0
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	•		Othe	200		Check only on			
of	Phys rthis ral di	T. To	1 Yes 2 No 27. Manner of Death	1 Impa 28a. Date of Ir (Month, I	ntient 2 🗆 E	ER/Outpatien 28b. Time of	t 3☐ DOA 28c. Injury Work	4 🗀 14013		d. Describe ho			y)
on	nding Ph tth. :: After thi e funeral	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Day Year)	Injury		<br Yes 2 ∐ No	0				
Division	I or Attandii after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	286. Place of	Injury - At hore	me, farm, str	eet, factory, office		28	f. Location (St. City or Town	reet and Numb	er or Rura	I Route Number,
ā	Ital or A	Cer											-
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physical Example (Check only one)	iner: On the basis	of examinati	ion and/or inv	estigation, in my or	oinion, death	occurred	at the time, da	ate and place,	and due to	the cause(s)
	To	Σ	29b. Signature and title of certifier				29c. License	number		2	9d. Date signe	d (Month,	Day, Year)
,	ιX		30. Nam and address of person who d	_ M.E	don't lie	22a) /T	0536	36			Oct	10,	2004
	Y١		KEVIN CARL	Sow M.	D. /	0700	29c. License 0536 Print) Charter	Onve	Co	umbi	, NO	21	044
	Sta Registi		31. Date filed (Mooth, Day Year 2004	A Pregio	strai s Sumat	Anon	E .						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** October 12, 2004 WINIFRED SEAL RUGEMER 4:00A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Roland Park Place Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 □ M 2 □ F Hours 93 Maryland Director 216-46-6240 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exercitor must be notified at XX Yes 2 No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21211 830 West 40th Street USA Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 270 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: δ Write XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Adelaide Bidwell permit. Pages 1 and 2 should be Department of Health and Mental Important: If itsm 271s marked any injury or other traumatic events. George Murray Seal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son 327 Taplow Road Baltimore, Maryland 21212 F.E.Rugemer Jr 20a. Method of Disposition

1XXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/16/04 Dulaney Valley Mem Gar Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. Ignature of Funeral Savige Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 2 days Preumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examine signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 X Xo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed should be d Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes XXNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital I or Attanding Physician: after death. Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 인 the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1XXVatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D25662 October 12, 2004 13 who completed cause of death (Item 23a) (Type, Print) 3333 North Calvert Street #540 Baltimore, Maryland 21218 MD Gregory L. Walker 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name /First_Middle_Last 2. Date of Death 3 Time of Death Month Day **Physician** MILTON ROLES J. 13, 2048 p M October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 804 S. Grundy Street Baltimore 8. Date of Birth (Month, Day, Year)
MAY 14,1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min **X**M 2□ F 213-14-8621 Director 80 MARYLAND Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 28e-f show other treumatic event, the Medical Ever-iner mark be notified at 1X Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 S. Items 23a GRUNDY STREET 21224 U.S.A. ss 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1943 – 46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER WAREHOUSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY LEROY ROLES MARY MARIE PHILLIPS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 WOODMONT COURT, JOPPA, MARYLAND 21085 JOSEPH GRUBB/ GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 tment of I 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 0 Department fraportant: If any injury or once. MEADOWRIDGE CEMETERY 10/16/04 ELKRIDGE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Earlier INC. FUNERAL HOME 200 700 S. CONKLING STREET, BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a HYPERTENSIVE ATMEROSCUEROTIC CARDIOVASCULAR /Medical DISEASE Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be exacuted burial-transit Due to (or as a consequence of) Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown diractor, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? Vital 1 Yes 2**X** No Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCENE Certification: To 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA of this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 XNatural 5 Pending 1 Tyes 2 No death. investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME October 14, 2004 ues 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 RUBIO 32 Aegistrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 5 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death October 13, 2004 **Physician** Gerald John Richardson 10:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford 324 Sweetbriar Ct. Joppatowne If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 □ F Yrs. Director 023-28-2334 Mar 24, 1939 | Massachusetts 65 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show ?7 la marked other than "natural", or Items 23a or 28a-f shov traumatic event, tre Maxical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Harford Joppatowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 324 Sweetbriar Court 21085 **USA** death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tool & Die Maker Aircraft Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 Ia marked oth any injury or other traumatic even Be Mildred (unk) Aldrich James Richard Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 Sweetbriar Ct., Joppatowne, Maryland 21085 Sandra L. Richardson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Gramation 3 Removal from State • 4 □ Donation Other (Specify) Hilltop Service Corp. 10-14-04 Towson, Maryland 22 Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 21. Signal PAM. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNE CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENA FALUNE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts) Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed DM that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SYNDROME SICK SINUS 1 Yes 2 No 3 Probably 4 Unknown Completed PENIDHMAN VASCULAN 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Vesidence 6 Other (Specify) 1 ☐ Yes 2 PNo ۵ 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 1 ☑Natural 28b. Time of 28d. Describe how injury occurred al or Attending P s after death, Il Director: After t Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/13/04 H40769 BURAIR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suire 114-116 RO DOHMEION EMMORTON 2021 21015 GREGORY m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar		State	of Marylar			f Health of Death		ental Hy	giene Reg. No.	1001	3	2771
	Physici /Medio		Decedent's Name (Fit AMARJ		st) SINGH						2. Date of Do Month OCT •	eath Day 12	Year 2004		Time of Death 4:00P
	Examir		4a. Facility Name (If not SUBURBAN	_		umber)			n, or Location IESDA	of Death			County of Dea	ath	
ı	Funeral Director		5. Social Security Number N/A	er 6. S		7. Age (In yrs. 70	last birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bi (Month, D JUNE 14	ay, Year)		rthplace ountry)	(State or Foreign INDIA
	aryland show	٦		. County	AND	10c. Ci	ity, Town or Lo		<u> </u>						nside City Limits
	with the M e or 28a-f be notifie	Director	10e. Street and Number 46 AVENUE	ITZERL.	AND		GENEVA	10f. Zip Coo	1202			10g. Citi	zen of What C	country?	A
20	72 hours after death with the Maryland naturel; or items 23e or 28e-f show deat Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	2 X Married	12. Was Dec Armed F 1 Yes If Yes, G Year or I	cedent Ever in U orces? 22 No ive		Vas Decedent Yes, specify (of Hispanic Or Cuban, Mexica		cify Yes or N Rican, etc.)	0-	INI 14. Race - Am Black, Wh Specify: AS	erican Ir ite, etc.	INDIAN
1213-0030	vithin 72 hour ne. han "naturel e Medical E.	Completed t	15.	Decedent's Ed	ducation de completed		(Give life. [one during mos tired)	st of worki	ng		nd of Business	s/Industr	у
ylana z	ould ba filed v Mental Hygie arked other t atic event, In	To Be Co	17. Father's Name (First		4		U.N.	. EXECU	18. Moth	er's Name	(First, Middle	, Maiden	Sumame)		
re, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or items 23e or 28a-f show any injury or other traumatic event, if a Madical Examiner must be notified at ODGe.		BIRENDAR S 20a. Method of Dispositi 1 □ Burial 2 🖔 Cr	INGH /I	BROTHER	20b. I		BELLE	TERRE	WAY	PŬTOMA ate	C_MD 20c. Lo	Town, State,	r Town,	
Dallillo	permit. Page Department Importent: fi any injury or once.		1 □ Buriai 2 ☑ Cri 1 □ Donation 5 □ 21. Signature of Funera	Other (Specify	y)	BAL HOB3	TWASH	Name and Ad	ATORY Idress of Facili	lO−16 FLE	CK FUN	ERAL	JREL, M HOME,I MD 207	NC.	
	Physician		23a. Part1. Enter the dishock, or heart fill Immediate Cause (Fina disease or condition			caused the deal each line.	th. Do not ente	er the mode of	dying, such as	cardiac o			MD 207	App	proximate rival Between set and Death
	/Medical Examiner	Examiner	sequentially list condition any, leading to immedicause. Enter Underlying Cause (Disease or injuntat initiated events	ons, hate	Due to	(or as a consec	quence of):								
,00/00	fficate ba executed g physician and as the burial-transit	edical Ex	resulting in death) Last	l	Due to	(or as a consec	quence of):								
O. DOX	The law requires that the death certif ite has been signed by the attending lage 2 should be detached for use a	hysiclan/M	IF FEMALE: 23b. Was decedent predint the past 12 mon 1 Yes 2 No 9 Unknown	ths?	1 ☐ Live	utcome of pregn birth 2 Feta nant at time of c	al death 3 🗌	Ectopic pregna Other (s <i>pecif</i> y				2	23d. Date of de Month	olivery Day	Year
cords, r.	en signed by	by P	Part II. Other significant	t conditions c	ontributing to	death but not res	sulting in the un	derlying cause	given in Part I	l.		tobacco u Yes 2 [se contribute t XNo 3□P		use of death?
וומו חפכל	The larate has	Completed	05 Wa								1 Tes	psy ormed? 2 No	prior to death?	utopsy fi complet s 2	indings available tion of cause of No
A 10 10	ding Phys T. After this funeral di	atlon; To Be	25. Was case referred to examiner? Yayes 2 No 27. Manner of Death 1 Natural 5 2 Accident	Pending investigation	28a. Date (Mor	Inpatient 2 🗓 of Injury ofth, Day Year)	ER/Outpatient 28b. Time of Injury	28c. l	04-	ursing Hor	(Check only one 5 Resided Resided Resided Reservible Re	idence 6	3 □Other (Spe y occurred	ecify)	
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;		Could not be determined	280. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, stre	et, factory, offi	се	2	8f. Location (City or To	Street and wn, State,	d Number or R	ural Rou	ite Number,
	the Hosp hin 24 hou the Funer npletely fill	Medical	(Check only 2 1 one)	Medical Exan	niner: On the I	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	estigation, in m	ny opinion, dea	nd place, a ath occurre	nd due to the ed at the time,	date and	place, and du	e to the	
	tige 5	2	29b. Signature and title	2/1	N	10		DO	ense number 057011				o signed (Moni	-	
	\		30. Name and address of MANTSH OZ	U. M.D.	86	se of death (Iter OO OLD Registrar's Signa	GEORGET		. BETHE	ESDA,	MD 20	814		· · · · · ·	
	Sta Registr			5 2004		and a digital		Louise	1						

		•	For State Registrar	State of M	aryland	•	artmen rtificate			and M		iene	nnl.	32770
	4	- R; 16 ∧	Decedent's Name (First, Middle,	Last)							2. Date of Dea	th	UUS	3. Time of Death
	Physicia /Medic		Ralp	h Davis	Sirman	n					October	12,	2004	4:50 P M
	Examin		4a. Facility Name (If not institution,	-	7)				Location of			4c. C	ounty of Death	
31	***		12 Glenwood Av		// /	-			svill	_	0.0		Baltimo	
b	Funeral Director		222-01-2160	5. Sex 1 M 2 □ F 7. A	ge (In yrs. Ias 85	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day APR 8,	1919	9. Birth Col	place (State or Foreign intry) Laware
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Mary a-f eh	tor	Maryland Baltin	ore			Caton	svi]	lle					1 ☐ Yes 2 No
	th the	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citize	n of What Cou	intry?
	ath w		12 Glenwood Av					212					USA	
36	be filed within 72 hours after death with the Maryland ttal Hygiene. Id Hygiene. od other than "naturel", or items 23s or 28s-f ehow event, the Modical Exam is a must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces d 1 Tyes 2 X If Yes, Give Year or Dates	? No	1	Was Deced If Yes, spec 1 ☐ Yes 2		ispanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Black, White	ican Indian, , etc. nite
000	2 hou		15. Decedent's	Education		16a. Dece	dent's Usua	d Occupa	ation			16b. Kind	of Business/I	
218	ithin 7 ne. nen "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	kind of wor DO NOT us	se retirea	()	t of worki				
121	e filed within al Hygiene. other than ' vent, I is Ma		12 17. Father's Name (First, Middle, La	act)		Me	at Sa	Lesm		e's Nome	e (First, Middle, I			ood Sales
Maryland 21215-0036	ld be fi ental F ked ot ic ever	To Be	Earl Sirman	151)					16. Mothe		a Davis	маюел эц	итате;	
ary	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rura	al Route Number	, City or T	Town, State, Zi	p Code)
	and 2 ealth m 27 i		Dennis W. Sirma	n/Son					Avenu		tonsvil			
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1	3 □Removal from State	e cen	netery, crei	nsition (Nan	ther plac	· 1			20c. Loca	ation - City or T	own, State
Itim	it. Pa irtmen irtent: njury		' 4 □ Donation 5 □ Other (Spe		Loude		rk Ce						altimor	
Ba	permit. Pages 1 and 2 Department of Health s Importent: If item 27 is eny injury or other tra QDCB.			Gregoreni	K						me, P.A Catons		e, MD 2	
Б			23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	nly one cause on each	line.			•	-					Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		s a conseque		CA	Roll	DVA	Su	lon !	24	un	ryan
ij.	Examiner		One Schale Bullion and Philosophia	b		1100 017.								
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		s a conseque	nce of):								
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a conseque	nce of):								
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9	ifficate g phys as the	edic		a										
.O. Box	ne death certificate be executed the attending physician and thed for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal d	eath 3	⊒Ectopic pro □ Other (spe					230	d. Date of deliv Month	ery Day Year
۵	requires that the deen signed by the		Part II. Other significant condition	s contributing to death	but not resulti	ing in the u	nderlying ca	ause give	en in Part I.		23e. Did tob	acco use	contribute to I	he cause of death?
rds	quires tha	ed by									1 □ Ye	s 2 🗆 I	No 3□Pro	bably 4 Dunknown
Records,	e law has b	Completed									24a. Was a autops perform	v	24b. Were auto prior to co death? 1 \(\sum Yes\)	opsy findings available impletion of cause of
Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?								(Check only on	e)		
of/	Phys this al dii	<u>2</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpat		R/Outpatier					me 5 Reside			fy)
no	ding th. After funer	tlon	1 Natural 5 ☐ Pending	(Month, D		Injury	M A	8c. Injury Work 1 🗀	/at <br Yes 2.⊟1		28d. Describe ho	w injury c	occurred	
Division	Attending or death.	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of I	njury - At hom	e, farm, str	eet, factory				28f. Location (St	reet and I	Vumber or Run	al Route Number,
Ö	tel or A	Cert	4 Homicide	Building, 6	etc. (Specify)						City or Towr	i, State)		
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Chack only O Madient C	Physician: To the bes xaminer: On the basis and manner s	of our minoria	- a-d/a-i-			similar dasa	M	and an also also a dis-			
	To the within 2 To the complet	M	29b. Signature and title of certifier	11 4			29c	. License	number	11	2:	9d. Date s	signed (Month,	Day, Year)
)	i		, Re	min	<u>ر</u>		() 5	579	-)cto	ber 13	3, 2004
	6		30. Name and address of person w	no completed cause of	death (Item 2	(Type.	Print)	R	e.	Su	ehe	マシ	212	25
T	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 5 2	to completed cause of the series of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the cause o	trar's Signatur	And And	de							

DHMH 17 Rev 1/2001

Registrar

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			1 State AMENTO TUDINA	State of Maryland / Depa			0001	A (1)
			1. Decedent's Name (First, Middle, Last)	#31 PER DVR G836 Q@	Thurstan Compean	Reg. No. 1	40.	3. Time of Death
¥.	Physici		John T.	Straub		October	Day 11, 2 00 4	12:00 PM
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	a
			1 Norgate (5. Social Security Number 6. Sex	7, Age (In yrs. last birthday)	CockeySville	8. Date of Birth	Da/tin	place (State or Foreign
ų.	Funeral Director			M 2□F 72 Yrs.	Months Days Hours Min.	Month, Day, Yea	ac Cou	hkeepsie, N
	and *		Usual Residence of Decedent 10a, State , 10b, County	10c. City, Town or Lo	ocation		* 3	10d. Inside City Limits
	he Maryli 28a-f sho	ector	Maryland Balto.	Co. Cocke	YSVI/le	10-	China at What Co.	1 ☐ Yes 2 No
	th with 1 23a or 3	al Dir	1 Norgate	Court	21030	log. C	Citizen of What Cou	4.
980	hours after death with the Maryland tural', or ttems 23a or 28a-f show al Expiritive must be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Aithed Forces?	Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F	offy Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	ican Indian, , etc. hite
21215-0036	72 hours 'natural'	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of working	16b.	. Kind of Business/li	ndustry
121	within ene. then	Jung	Elementary/Secondary (0-12)	College (1-4or 5+)	DO, NOT use retired) Enginee	(Engine	er
	be filed within 72 hatata Hygiene. d other than "natuevent, the Medical	Be C	17. Father's Name (First, Middle, Last)	0/ /		(First, Middle, Maid	en Sumame)	
Maryland	ould be Mental Marked c	2	John Theodi	12	Helen	Chi	K	
Mar	nd 2 should Ith and Men 27 Is marke traumatic		19a. Informant's Name/Relationship (Ty	po, Print) Daughte 196. Maili	ng Address (Street and Number or Rura)	Route Number, City	y or Town, State, Zi	Code)
Je,	es 1 and of Health fitem 27 r othar tr		20a. Method of Disposition	20b. Place of Dispo	osition (Name of Damatory or other place)	ate 20c.	Location - City or T	own, State
Baltimore	Pag nent ant: I		Burial 2 Cremation 3 Rules 4 Donation 5 Other (Specify)	emoval from State Du aney		5,2004	Timoniu	m, MD.
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licental	2 (1.) te	Name and Address of Facility PACETU, ATTERNAT	ives Fun	eral+Cre	makon Ctr
			23a. Part1. Enter the disease, or compli	ications that caused by deal. Do not ent		TIMONI L	im, 1910.	Approximate
	Pnysician	5 6	shock, or heart failure. List only or Immediate Cause Final disease or condition	le cause on each line.	USRIOSIO			Interval Between Owset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of);	70			<u> </u>
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	·			
	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury) that initiated events	:				
50,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
38760,	phy:	dlcal		l				
.O. Box (at the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	very Day Year
₾.	₽ B B			ntributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacci	o use contribute to	the cause of death?
rds,	w requires been sign should be	ed by				1 ☐ Yes	2 No 3 ₽ro	bably 4 DUnknown
Vital Record	aw as b	Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
at B						performed?		2 □ No
Z.	Physician: T this certificat al director, pa	To Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death	11	6 ☐Other (Speci	(4.1
n of			27. Minuer of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury		8d. escribe how in		'9)
Division	ten leat tor: the	catle	accident investigation Suicide 6 Could not be	and the second	M 1 Yes 2 No	06 1		
DIV	al or Atten after deat Diractor: d in by the	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	8f. Location (Street and City or Town, Sta		ai Houte Number,
	To the Hospital or At within 24 hours after of To the Funeral Diracl completely filled in by	Medical C	29a. Certifier 1 Sortifying Physical (Check only one)	sician: To the best of my knowledge, death	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as :	stated. to the cause(s)
	To the I within 2. To the I complet	Mec	29b. Signature and into of certifier	and manner states.	29c. License number	29d. [Date signed (Month)	Day, Year)
	X	١	1 AMUGU	<u> </u>	236814	1 /	0/13/	04
	10,		30 Name a draws of person who co	empleted cause of death (Item 23a) (Type,	Print)	,	6	1
	-		31. Date filed (Month, Day, Year)	32. Registrar's Signature				

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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	rds, P.O
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	of Vita
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12 Month **Physician** 5.31 PM 10 Jane Salvetti 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 12, Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Yrs 1923 Kentucky 440-26-6747 81 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene item 27.38-f shawked other then "natural", or flems 23s or 28s-f show other treumatic evant, Ite Madical Exemines must be notified a 1X Yes 2 ☐ No Directo Baltimore Maryland N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 4608 Furley Avenue u. s. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Unknown Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ٩ Benjamin Brock Esther Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Salvetti (Son) 4302 Raymar Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 = 0 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Department Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 10/15/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Preumonia /Medical resulting in death) Due to (or as a consequence of): Examiner Upper ojastraintestinal Due to (or as a consequence of): bleeding Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner burial-transit The faw requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No should be detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? 4 ☑Unknown 1 ☐ Yes 2 ☐ No 3 Probably Diabetes mellihis peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension page 2 certificate has autopsy performed) 1 ☐ Yes 2 ☐ No 2 No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funaral Director: After this completely filled in by the funeral di 28b. Time of 28a. Date of Injury (Month, Day Year) Certification: 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Hukhery 10/12/04 RES OOO 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

Indrani Mukhe Gie M.D. good Sanaritan Hospital 5601 Loch Raven Bld Baltimore - 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene

						Certificate	e of	Death		Reg. No.	004	32776
	Physic	ian	Decedent's Name (First, Middle, La.						2. Dete of Month	Death Day	Year	3. Time of Death
-	/Medi		Bonnie Ruth	Stewart						er 10,	2004	2:45 PM
	Exami		4a Fecility Name (If not institution, giv-					4b. City, Town	n, or Location of De	eath 4c. Cou	unty of Death	
			415 Calvary Ro	ad				Church		1	Harfor	d
	Funeral		5. Social Security Number 6. S		e (In yrs. last bi	rthday) If Undar Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of Month,	Birth Day, Year)	9. Birth	place (State or Foreign
	Director		246-28-3223	□M 2ŽXF	79	Yrs.	Days	Tiouis				th Carolina
	D .	•	Usual Residence of Decedent									
	Pho Pho		10a. State 10b. County		10c. City, Tov]	10d. Inside City Limits
	W T	Ş	Maryland Harford		Church	nville						1 □ Yes 2 🛣 No
	# 28 #	- F	10e. Street end Number			10f. Zip	Code			10g. Citizen	of What Cou	intry?
	h wil	a D	415 Calvary Road			21	L028			USA		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be nothed at	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U,S.				n? (Specify Yes or Puerto Rican, etc.)		Race - Americ	
	a a a	Ξ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give	No				Pueπo Hican, etc.)		Black, White,	, etc.
21215-0020	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:		Spe	ecity: Wh	nite
Ò	2 ho	Completed	15. Decedent's Ed	lucetion	16a	. Decedent's Usua	I Occup	ation		16b. Kind o	of Business/In	ndustry
215	7 un u	pie	(Specify only highest gra	de completed) College (1-4or 5		(Give kind of wor life. DO NOT us	rk done se retired	during most o d)	if working			
	with a second	E	12	College (1-401 5	*/	Pay Roll	C1.	ork		Choo	Manuf	acturing Co
ō	Hyg Sthe		17. Father's Neme (First, Middle, Last)			TOT INTE			Name (First, Mid	dle, Maiden Sur	name)	acturing to
a	d be so de de de de de de de de de de de de de	To Be	Emerson E.	Stuart				Enni	s (unk		Stanle	
2	hou M M mari	F	19a. Informant's Name/Relationship		198	. Mailing Address	(Street		or Rurel Route Nu			-
Maryland	d2s thar 7 is trau		Robert Stewart -			_			nurchvil]	-	·	•
	1 an Heal		20a. Method of Disposition	ilabballa					Date		on - City or To	
ğ	permit. Pages 1 and 2 should be filed within 72 hours after death with tha Marylan Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show mixportant: if Item 27 is marked other than "natural", or items 23s or 28s-f show hiptory or other traumatic event, the Medical Exercitor must be notified at once.		1 □ Burial 2 □ Cremation 3 □	Removal from State		f Disposition (Nan ry, crematory or o						
	men men tant:		4 ☐ Donation 5 ☐ Other (Specify		Mt. Zi				n. 10/14/	'04 Bel	Air, N	Maryland
Baltimore,	aparti aport ny In		21. Signature of Funeral Service Licen	S00		22. Name and			McComas			
ш	205 8 3		Mails T. Z	BOL.		1317 C	'oke:	sbury I	Road, Abi	ngdon,	Maryla	and 21009
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	plications that caused	the death. Do	not enter the mode	e of dyir	ng, such as ca	ırdiac or respirator	y arrest,	1	Approximate
1	Physician		Shock, or fleatt failure. List only	one cause on each in	ю.						1	Interval Between Onset and Death
1	/Medical		Immediate Cause (Final	W.	o Fral	catic	10	1400	Canco	240		2 month
Ĕ.	Examiner		disease or condition resulting in death)	a		consequence of):		7	Cerro	<i>V</i> •	<u> </u>	2 1100/01/0
		Je.			Dub to (or as a	consequence or).		U			1	
	icate be executed physician end s the buriel-trensit	Examiner		b	Due to for se a	consequence of):						
<u>,</u>	n en	Еха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury		Due to (or as a	consequence or).						
68760,	sicia bur		Ceuse (Disease or injury that initiated events	C	Due to /or oo o							
9	ntificate ng phy es the	edicai	resulting in death) Last	'	Jue to (or as a	consequence of):					1	
	centi ding	2		d								
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j.	the d	Physician/	Part II. Other significant conditions co	ontributing to death bu	ıt not resulting i	n the underlying ca	ause giv	en in Part I.				o the cause of death?
7	that tha de ned by the a detached t								1	☐ es 2□ N	o 3□Pro	bably 4 Unknow
or vital Records,	S P 8	by									Oah W	ere autopsy findings
0	v require been signal	etec								as en autopsy rformed?	av	vailable prior to
ည	has b	ğ							_		of	death?
	The la	Completed							1	LYes all	5 1[☐ Yes 2☐ No
<u> </u>	ician: The certificata rector, pag	Be	25. Was case referred to medical examiner?					26. Place o	Death (Check on	ly one)		
_	S 50 D	ဥ	1□ Yes 2□ No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient 3□ DO	A Oth	er: 4 🗆 Nursi	ing Home 5 🖪 🛱	esidence 6 🗆	Other (Specif	fy)
0			27. Manner of Deeth 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of 28	8c. Injur Wor	y at	28d. Describ	e how injury oc	curred	
<u></u>	Attending or death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investigation			М		Yes 2 □ No				
UIVISION	or Attence after death Director:) 	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, fa	rm, street, factory	, office			n (Street and Nu Town, Stete)	ımber or Rura	al Route Number,
5	s afte	Certification:	- Individuo	building, atc	. (Optony)				Only of	oun, ololo,		
	sspita hours mere y fille		29a. Certifier 1 Certifying Phy	ysician: To the best of	f my knowledge	, death occurred a	at the tin	ne, date and s	place, and due to t	ne cause(s) and	manner es s	stated.
	To the Hospital or Atte within 24 hours after de To the Funeral Directo complataly filled in by the	edicai	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination ar ted.	d/or investigation,	in my o	pinion, death	occurred at the tim	e, date and plac	e, and due to	o the cause(s)
	Vithin 2 To the complain	Ĭ	29b. Signature and title of certifier		^ ^	29c	Licens	e number		29d. Date sig	gned (Month,	Day, Yeer)
			1	-	17.4	,	0	450	390	Octob	er 11	2004
			30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)			•			,
			my masson		South	ALWIN	bo	Roac	1 # 20	Bel	Air, 1	MD 21014
(3)	Sta	ate.	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	~ 3				/		
1	Registi		OCT 1 5 200	14 / 200	e the	Asset)						

SAMANTHA L. SHIFLET

- 7 1/11	na L. S	ΠI.	For State Registrer		State o	f Marylan	-	artment of H tificate of I		Mental Hygi	ene g. No. 0 0 1;	32777
	Physici		Decedent's Name (SAMANTH							2. Date of Death Month OCT •	8, 2004 Year	3. Time of Death 0344 A M
	/Medic Examir Funeral	7.1	4a. Facility Name (If no QUAKER H) 5. Social Security Num	ILL ROAL) Sex	mber) 7. Age (In yrs. i	last birthday)	WESTMII	If Under 24 Hrs.		4c. County of Death CARROLL	lace (State or Foreign
	Director		212-02-81 Usual Residence of D	ecedent	1□ M 2Ū F	22	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, AUG • 27,		MD.
	e Marylar 8e-f show Illied al	ctor	MD.	Ob. County CARROL	L		y, Town or Lo				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23a or 24	Funeral Director	10e. Street and Numb		ROAD			10f. Zip Code	21771	10	g. Citizen of What Cour	itry?
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avant, the Medical Examinar must be notified at ances.	by	11. Marital Status 1 Never Married 3 Widowed 4	41	12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	2 XNo ve	1	Was Decedent of H f Yes, specify Cuba I □ Yes 2☐ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: WH]	etc.
21215-0036	I within 72 ho lene. r than "natur the Medical	Completed	(Specify Elementary/Second 9th		ducation ade completed) College ((Give life. L	dent's Usual Occupi kind of work done o DO NOT use retired OMEMAKER	durina most of work	king	6b. Kind of Business/Ind OWN HOME	dustry
Maryland 2	uld be filed Aental Hygid rked other tic avant, the	To Be C	17. Father's Name (Fi		•					JOANNE WA	•	
	and 2 should leith and Men 27 is marke er traumatic		19a. Informant's Nam JOHN DUTT								City or Town, State, Zip MARYLAND	Code)
Baltimore,	Pages 1 ament of He ant: If Itam iury or other		20a. Method of Dispos 1 ☐ Burial 2 X 1 ☐ Donation 5	Cremation 3		1 0	emetery, cren FIMORE	sition (Name of natory or other plac TWASHINGT	ON 10/14	4/04 L	Oc. Location - City or To AUREL, MARY	LAND
Balt	permit. Page Department of Important: If any injury or		21. Signature of Fune	17	Eun	D 1100	57	5224 EAST	ERN AVE.	, BALTIMO	ZEILER & SORE, MARYLAN	ID 21224
	Pnysician /Medical Examiner		Immediate Cause (Fi disease or condition resulting in death)	failure. List only	one cause on o	caused the death each ne. (or as a consequ	1-pl	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
68760,	icate be executed physician and sthe burial-transit	edicai Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Las	ring jury	c	(or as a consequ						
O. Box	the death certifi by the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 N 9 Nhnown	onths?	1 ☐ Live I	tcome of pregna birth 2 □ Fetal nant at time of de own	death 3	Ectopic pregnancy Other (specify)	-		23d. Date of delive Month	ry Day Year
ords, P.	w requires that been signed t should be deta	by	Part II. Other significa	ant conditions	contributing to d	eath but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
al Records,	The ate his page	Completed								24a. Was an autopsy performe 1 Yes 2	prior to cor ed? death?	osy findings available inpletion of cause of 2 No
n of Vital	ding Physician: Th. h. After this certificate funeral director, pag	on; To Be	25. Was case referred examiner? 1. Yes 2 No. 27. Manner of Death 1 Natural		Hospital: 1 28a. Date	of Injury	ER/Outpatien 28b. Time of Injury	t 3 DOA Other	er: 4 ☐ Nursing Ho	th (Check only one, ome 5 Residen 28d. Describe how	v	AT SCENE
Division	or Atten	Certification:	2 Accident 3 Suicide 4 Homicide	investigation in	28e. Pl ce	Hinjury - At ho	ONK ome, farm, stre STREZ		Yes 2 No	28f. Location (Stree City or Town,	et and Number or Rura State)	Route Number,
)	ne Hospital n 24 hours a na Funaral I	Medical (29a. Certifier 1 (Check only 2 one)	Certifying P Medical Exa	miner: On the b	e best of my know asis of examinations oner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as st e and place, and due to	ated. the cause(s)
,	To the within 2 To tha complet	W	29b. Signature and litt	le of fertifier	low			29c. License O.C	number .M.E	290	Date signed (Month, LOCT. 8, 2	
4			30. Name and addres		completed cau	se of death (Item			Baltimor	e, Maryla	and 21201	
:-	Sta Registi		31. Date filed (Month,	Day, Year)	14	Registrar's Signal	ture Los	de la				

			A Section of the sect	partment of Health and Nertificate of Death		ene g. No. 0 0 4	3:778
	Physici	an.	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Barbara Sharpe			1, 2004	3:00 A.M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
	1		1819 Walnut Ave. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Dundalk If Under 1 Year If Under 24 Hrs.	O Date of Birth	Baltimore	
20	Funeral Director		219-50-4147 1 M 2 F 55 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,		olece (State or Foreign ntry)
4	ס		Usual Residence of Decedent		Feb. 14,	1949 Mar	yland
	anylar show	_	10a. State 10b. County 10c. City, Town or	ocation		1	10d. Inside City Limits
	San-f	Director		da1k			1 ☐ Yes 2√☐ No
	with t	Ö	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coul	ntry?
	eath ns 23	Funerai	1819 Walnut Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Deceded of Hispania Origin? (Sp.	oofy Vos er No	U.S.A.	nga ladina
"	r Hen	Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 XNo	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
8	72 hours after death with the Maryland natural; or Items 23a or 28a-f show likal Exentral must be profitted at	þ	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Wh	ite
5	be filed within 72 hours after death with the Marylan stal Hygiene. Ed other than "natural", or flems 23e or 28e-f show other than "natural", or flems 23e or 28e-f show event, the Medical Exemplear nation and the notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ina 10	6b. Kind of Business/In	dustry
121	within ene. then "	m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NDT use retired)			
2	e filed within al Hygiene. other then		9th 17. Father's Name (First, Middle, Last)	omemaker 18. Mother's Name	/First Middle Mi	Own Home	
an	lid be lental ked o	To Be	Robert Lempitsky	Mary		alcen Sumame,	
Maryland 21215-0036	should be ind Mental i marked umatic ev	-		ing Address (Street and Number or Rura		City or Town, State, Zip	Code)
	and 2 :			9 Walnut Ave., Dun			
ore	ges 1 and 2 should nt of Health and Mer i if Item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cr	osition (Name of Ematory or other place)	Date 20	Oc. Location - City or To	own, Stete
Ë	Pag ment tant: I		`4 □Donation 5 □Other (Specify) BaltoW		15-04 1	Laurel, Md.	
Baltimore,	permit. Pages Department of h Important: If Ite any injury or of		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Bradley-Ashton-Ma	tthews Fu	ineral Home	e, Inc,
18			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac of	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of the control of the cont	aver			
······································	Examiner		End Store	COPD			
	n =	ner	Sequentially list conditions, if any, leading to liminoidate cause. Enter Underlying				
	and trans	Examiner	Cause (Disease or injury that initiated events c.				
8760,	ate be executed hysician and the burial-transit		Due to (or as a consequence of):				
387	physicate s the l	dicai	d				
Вох 6	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	465		23d. Date of delive	in.
ă	death e atter	iciai	in the past 12 months? 1 Yes 2 MNo 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)			Day Year
		hys	9 □Unknown				
S,	90 20	ру Р	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ord	w requir been si should I				1 Yes	2 No 3 Prob	ably 4 ☐Unknown
Records,	has bu	Completed			24a. Was an autopsy	prior to con	psy findings available ripletion of cause of
표	cate				performe 1 ☐ Yes 2 ☐	d? death? No 1 ☐ Yes	2 No
Ħ	ysician: The is certificate his director, page	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
o	Phys rrthis gral dii	: To	27. Magner of Leath 28a. Date of Injury 28b. Time	TILL S DOX 4 Nursing Hor	ne 5 Residence 28d. Describe how	be 6 ☐ Other (Specify	')
lon	Attending In death. ector: After by the funer	atior	i Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		injury coodinou	
Division of Vital	l or Attending Ph after death. Director: After th in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street	et and Number or Rural	l Route Number,
Ö	ital or A rs after ral Direct led in by	Cer	Durinity, vic. (opposity)		City or Town, S	olate)	
3	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, dea 2 Madical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the caused at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	2	29b. Signature and little of certifier	29c. License number	29d	Date signed (Month, L	Day, Year)
,	3		Manua Xyy, MI)	1052053		11/12/04	
,			30. Name and address of person who compléted cause of death (Item 23a) (Type	on Rd ball	mne.	MD 212	25
	Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	de))		
	Registr	ar	OCT 1 5 2004				

1			For State Registrar	State of Ma	-	irtment of Health and tificate of Death		ene 1. No. () () ()	35779
			Decedent's Name (First, Middle, Last	st)			2. Date of Death		3. Time of Death
П	Physicia		Donte Randolp	h Taylo:	r		Month OCTOBER	10. 2004	4:14P. M
	/Medid Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of De		4c. County of Death	14.141.
1	_xamii	•	UNIVERSITY HOSPIT	TAI.		BALTIMORE		N/A	
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birthr	place (State or Foreign
ш	Director		217-96-0555	□M 2□F	23 Yrs.	33,5	Dec. 14		aryland
	pu.	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	ehor ehor	5	Maryland N/A	4		imore			1 Yes 2 □ No
	the M	Director	10e, Street and Number			10f. Zip Code	100	g. Citizen of What Cour	ntry?
	with	급	2489 W. Colds	oring Lar	16	21215		JSA	,
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13. V	Vas Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Americ	can Indian,
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow lical Examinet must be notified at	Completed by Funeral	1 ★ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	f Yes, specify Cuban, Mexican, Pu □ Yes 2 (□ No <i>Specify:</i>	erto Rican, etc.)	Black, White,	
21215-0036	hour	ed	15. Decedent's Ed		16a, Deced	tent's Usual Occupation	16	6b. Kind of Business/In	dustry
15	in 72 n "na	piet	(Specify only highest gra	de completed)	(Give	kind of work done during most of w DO NOT use retired)	vorking	nstructi	
212	d within jiene. r than "	mo	Elementary/Secondary (0-12) 11th grade	College (1-4or		borer		JIIS CI UC CI	on co.
	othe	Be C	17. Father's Name (First, Middle, Last)				ame (First, Middle, Ma	aiden Sumame)	
/lar	uld by Menta Irked Itic e	ToE	Melvin R. Tay	lor, Jr.	•	Karri	n Harris		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 ehow or other traumatic event, It a Medical Examinet must be notified at		19a. Informant's Name/Relationship (Karrin Harris/			g Address (Street and Number or W. Coldsprine			
Je,	is 1 au of Hea item othe		20a. Method of Disposition		20b. Place of Dispo	natory or other place)	0/10/04	oc. Location - City or To	own, State
Ë	Page nent c int: If		1 ☐Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Arbutus	Memorial Parl	k Ar	butus, M	aryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra gnce.		21. Signature of Funeral Service Ligar	see .	5:	Name and Address of Facility C	natman-Ha own Rd Ba	rris Fundation	eral Home Maryland
			23a. Part1. Enter the disease, or com shock, or hear failure. List only	plications that cause					Approximate Interval Between
1			Immediate Cause (Final	one cause on each I	H (P			Onset and Death
1	Prrysician /Medical		disease or condition resulting in death)	a Due to (or as	a consequence of):	werdo t Wom			
	Examiner				,,,				
	N 5	er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):				
	outed id ansit	Examiner	if any, leading to immediate auto. Eller Index in Cause (Disease or injury that initiated events	C					
o,	an ar irial-t	EX	resulting in death) Last	Due to (or as	a consequence of):				
8760	death certificate be executed e attending physician and of for use as the burial-transit	dicai		d					
9	ing pl		IF FEMALE:					1	
Вох	leath certific attending p I for use as	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy		23d. Date of deliver	ery Day Year
0.	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death 5	Other (specify)			,
Δ.	that the de led by the a detached i	Ph	Part II. Other significant conditions of	ontributing to death t	out not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the	he cause of death?
Records,	w requires that the been signed by th should be detache	ed by					1 ☐ Yes	2 No 3 Prob	pably 4 Dunknown
900	aw 2 sh	Completed					24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
Ä	The late happage	mo.					performe	ed? death2 □ No 1 Maryes	2□ No
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			26. Place of E	eath (Check only one)		
Ţ	S S D	Tof	1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien	t 3 DOA Other: 4 Nursing	Home 5 Residen	ce 6 □Other (Specif	'y)
n of	ng Pl		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, D	ury 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
sio	Attanding r death. ector: After	cati	2 Accident investigation 3 Suicide 6 Could not b	(0((3)	/	M 1 □ Yes 2 WNo	Jone C.		
Division	or At	Certification;	4 Homicide determined	200, Place of Iti	july - At home, farm, str tc. (Specify)	eet, factory, office	City or Town,	et and Number or Rura State) 24% (1)	cle West Contact
	Hospital 4 hours a Funeral C		One Continue of Continue Di	velejen. To the book	91		Mut s	this my 14	my found
	Hos 24 ho Fun stely f	Medical			of examination and/or in	n occurred at the time, date and pla restigation, in my opinion, death oc			
	To the Hospital or Attanding Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral i	Me	29b. Signature and title of certifier	4		29c. License number	290	d. Date signed (Month,	Day, Year)
	> 0		110.1	11 16	_ ~	O.C.M.E.	OC"	TOBER 11,20	004
	n		30. Name and address of person who	completed cause of	death (Itom 23a) (Type,	Print)			
			THE UDSREMIK	ing		111 Penn Street,	Baltimore	, Maryland	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1 1			
	Regist	ar	OCT 1 5 200	4 Stre	va 19	sports			

			- For Amend Item 27 Registrar	State of Maryland / Dep per Dr., G836, 10/15	artment of Health and 104dhb rtificate of Death	Mental Hygie	ne 2004	32780
	Physici	n	1. Decedent's Name (First, Middle, Las	"		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	EIWOOD [nomas	1 0 T	September		
4	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death	
	Funeral		Greater Baltimore 5. Social Security Number 6. Se	x 7. Age (In yrs. last birthday)	Towson If Under 1 Year If Under 24 Hrs	8. Date of Birth	Baltimore 9. Birth	place (State or Foreign
	Director	1	134-97-1026	M 2□F 86 Yrs.	Months Days Hours Min	Aug.3,	918 Non	th Carolina
	and aw	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. tnside City Limits
	Marylan -f show	ţoţ	MD	Ral-	himore)			1 XYes 2 □ No
	or 28e	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
	ath wil		5313 Nas	de Ave	21215		USA	
	er der Items	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
036	urs aff	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	ade
5-0036	within 72 hours atter death with the Maryland ane. than "natural", or Items 23a or 28e-f show as Nedleal Estanii at must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation 16a. Dece	dent's Usuat Occupation a kind of work done during most of wo	orkina 16b	. Kind of Business/In	ndustry
2121	within iene. than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	E	segne	han
	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	den Sumame)	
a	ould be filed Mental Hygi tarked other tatic event, I	To B	Wash Tho	mas	1/0 e	1,11,20	20/01	
Maryland	2 shou and M Is mai		19a. Informant's Name/Relationship (7	ype, Print) 19b. Maili	ing Address (Street and Number or R	ural Rout) Number, Ci	ty or Town, State, Zij	p Code)
-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, I'm Medical Extrainer must be notified any once.	1	allarie hon	Vas Doughter 501	2 Chalgrove	Ave, Ba	10 MD	21215
Baltimore	ages Int of H		20a. Method of Disposition Buriat 2 Cremation 3	Removal from State	matory or other place	711/04	Location - City or T	own, State
Itti	artme ortant injury		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	- 0010	2 Name and Address on Facility	9	alw.M	D
100	permit. Departi Importi any inj		112~ 4-	1 M1363 V	aughn Cure	Syl Fu	th. MD	21212
6	4		23a. Part1. Enter the disease, or comp shock or heart failure. List only	cations that caused the death. Do not en	ter the mode of dving such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a bradyarrhyt	1			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence by)	4			
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (orașia consequence of):	,			- 2
	xecuted and Il-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· cardiogenic	Shock			2 days
90,	cate be executed obysician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequience of):				
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier Check only (Check only one) Certifying Physics 2 Medical Exemption	/sicien: To the best of my knowledge, deal iner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place exestigation, in my opinion, death occurred.	e, and due to the cause urred at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	Ω	29c. License number	29d.	Date signed (Month,	Day, Year)
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_	0		30. Name and address of person who a	completed cause of death (Item 23a) (Type, 6569 N)-Chacle		BUT MI) 2125	U
	Sta	te	31. Date filed (Nepth Day Year)	72. Registrar's Signature	3 Julie Wol	mer, MI	4126	7.7
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	Physici /Medi		Wendy	ANNE	Wirth			October	11 200	Year 14	2200 p M
	Examir	er	4a. Facility Name (If not institution, give 1331 Sulpher Spr				or Location of Deat utus	h	4c. County Bal	of Deeth	e
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	Director		216-72-3867 Usual Residence of Decedent	JIM ZUBET	78 Yrs.			Feb. 5	1950	(MD)	"U.S.A.
	Maryland e-f show	tor	10a. State 10b. County Balt	mere	10c. City, Town or L	OCATION OR but us	2-			100	d. Inside City Limits 1 Yes 2 10
	th with the M 23e or 28e-f	al Director	10e. Street and Number 1331 Swipher	SPRING		10f. Zip Code	1227	10	og. Citizen of V	What Countr	y?
036	after dea or Items	by Funeral	11. Marital States 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 Yes 2 H If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Span Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - America ck, White, et	ic.
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:	Sta Regist		31. Date filed (Month, Day, Year) 0CT 1 5 200		ar's Signature	Sparks					

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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		X		30. Name and addre	A . A- A	completed cause	of death (Item			Stree	et. Ra	ltimore	e. Marce	land	21201
					h, Day, Year)	32. Reg	istrar's Signat		land				-, <u>- , , , , , , - , </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 7, 2004**Physician** October 7:40 a M Roger Cooper Wedge /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 2204 Snydersburg Road Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr 21, 1939 9. Birthplace (State or Foreign Country) MaryLand 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 11X7 M 2 1 7 F Yrs. 65 213-36-8919 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ? Is marked other then "neturel", or Iteme 23a or 28a-f ehow traumatic event, the Modical Exerciper must be notified at Westminster 1 ☐ Yes 2√2 No Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2204 Snydersburg Road 21157 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1⊠Yes 2□No 1960− If Yes, Give Year or Dates: 1963 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Water Pump Company Installer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert R. Wedge Alice E. Cooper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is eny injury or other trat once. 2204 Snydersburg Rd, Westminster, MD 21157 Linda E. Wedge, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/11/2004 Hampstead, MD Shiloh UM Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) M00723 21. Signature of Geral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4200 disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. escribe how injury occurred After t Certification: or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 151 vel. 2059 Baltimi Kanit 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

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	8a-f	scto	2410	imore		White									1 ☐ Yes 2 🌠 No
	with ti	Funeral Director	10e. Street and Number 5818 Gambrill	p.d			10f. Zip	211	162				zen of What	Count	ry?
	s 23s	erai		12. Was Decede	nt Ever in II	C 12.1	Man Danad			inin'i (Co.	noite V an an Na	US	A 14. Race - A	marian	n todion
	Itam Itam	Ę.	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie	Armed Force	es?	.5.	Yas Deced	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)).	Black, V	Vhite, e	tc.
39	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 □ Yes 2	2 K i No	Specify:				Specify:	Whi	ite
ŏ	2 hor	ted	15. Decedent			16a. Dece	dent's Usua	I Occupa	ation	* = \$		16b. Ki	nd of Busine	ss/Indu	ustry
2	thin 7	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of wor))	t or works	ng	шо	alth (7020	
7	ed wi	Completed	12 yrs.	<u> </u>		INUL	se Ai	.u						are	.
Ind	be filed within 72 hours atter death with the Maryland tal Hyglene. d other than "natural", or Itams 23c or 28a-f show event, fre Medical Examinal must be notified at	Be	17. Father's Name (First, Middle, L Peter A Zebac					ŀ			(First, Middle M. Gea		Sumame)		
<u>Y</u> a	Men Men Marke Marke Marke	2						12							
Maryland 21215-0036	32 st h and 7 Is n traun		19a. Informant's Name/Relationsh Raymond Makow	ski S(son			-				<i>i Route Numb</i> Lte Mar				Code)
	1 and Healt am 2		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of			ate		cation - City		vn. State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23c or 28a-f show any injury or other traumatic event, Ita Medical Examinat must be notified at ODCe.		1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		Oak	emetery, cren Lawn	cem.	ther place	θ) (Oct. 200	18		timore		
Ball	Depart Import any in		21. Signature of Funeral Service L	icensee Con	rell	$\begin{pmatrix} c_0^2 \\ c_0 \end{pmatrix}$	nnell 10 So	y Fu 1ler	s of Facility Inera S Po	I Hon int F	ne Of D Rd. 212	unda 22	lk		
	, W		23a. Part1. Enter the disease or o	complications that cau	sed the death										Approximate Interval Between
Ц	Pnysician		Immediate Cause (Final disease or condition	mo	100	todia	1800	201			ng co		01		IntervatiSetween Onset and Death
	/Medical		resulting in death)	Due to (or	as a conseq	uence of):			<u> </u>		7		V 1		2000
E	Examiner		Sequentially list conditions.	b							131				
	pg it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseq	uence of):									
	ecute and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):								-	
760,	icate be executed physician and s the burial-transit	caiE		20010 (01	as a conseq	denos on.								1	
687				d										+	
×6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	me of pregna	ancy							3d. Date of	deliven	v
Вох	atter for L	ciar	23b. Was decedent pregnant in the past 13 pronths?	1 ☐ Live birth	n 2 ☐ Feta	Ideath 3	Ectopic pre						Month		y Day Year
o.	the d y the	iysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknow				,,							
٥.	s that ned b	by Pł	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco u	se contribut	e to the	cause of death?
Vital Records,	quires in sign	d be									X	Yes 2[]No 3□	Probal	bly 4 □Unknown
000	aw requir s been si 2 should l	Completed									24a. Was				sy findings available
R	The late has	E									autoj perfo	psy ormed? 2 No	death	1?	pletion of cause of No
ā	sician: The law s certificate has t lirector, page 2 s	0	25. Was case referred to medical						26. Place	of Death	(Check only o	-/->-			
	tending Physician: The leath. tor: After this certificate hithe funeral director, page	ToB	examiner? 1 🗆 Yes 2 No	Hospital: 1 🗆 Inp	atient 2	ER/Outpatien	t 3 DO	A Othe	er: 4 □ Nu	rsing Hor	ne 5 Resi	dence 6	Other (S	pecify)	
n of	ding PI n. After th funeral		27. Manner of / eath 1 Natur I 5 ☐ Pending	28a. Date of I (Month,	Injury <i>Day Year)</i>	28b. Time of Injury	2	Bc. Injury Work	at ?	2	28d. Discribe	how injur	y occurred		
sio	Attending or death. actor: After by the fune	cati	2 Accident investig 3 Suicide 6 Could n	ation of he			М		/es 2□			_			
Division	for Attendated after death Diractor:	Certification;	4 Homicide determine	200. Place of	Injury - At he etc. (Specif	ome, farm, str y)	eet, factory	, office		1	28f. Location (S City or Tox			Rural I	Route Number,
	pital ours a aral [29a. Certifier 1 Certifying	Physician To the he	not of my lead	uuladaa daash		at the size		d alasa					
	e Hospital 24 hours a E Funaral I etely filled	edical	(Check only 2 Medical E	Physician: To the be xaminer: On the basi and manner	s of examina	ition and/or in	estigation,	in my op	oinion, dea	th occurre	and due to the ed at the time,	date and	place, and	due to t	ted. he cause(s)
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	Med	29b. Signature and title of certifier	7/1/	/		29c	License	number		,	29d. Dat	a signed (Mo	onth j Da	ay, Year)
}	->		Kuchen	14.41	UCA	18	1	03	365	81	4	1	0/15	1/2	14
	h		30. Name and address of person v	no dompleted cause	of death Item	тов Туре.	Print)		1	1).	2-1	1		10 - 5
)		Bichard L	, HUS/19	15	25 6	156	2	DE	1.50	ITES	500	100	50	nMD
	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	iture	,								
7	Registi	rar	OCT 1 5 2	2004 200	بمصمامهم	19	poo	res	/						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Year Physician Wayne Allen Zimmerman 8:17 10,2004 October /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6506 Beachwood Drive Columbia Howard 8. Date of Birth (Month, Day, Year) NOV. 20, 1961 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** M 2□ F 213-93-4167 42 Director Florida Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes XXNo ò Ellicott City MD Howard Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9306 Joey Drive 21042 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. ia marked other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Pharmaceuticals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked c any injury or other traumant. Carl Zimmerman Margaret Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Zimmerman-father 118 Riverview Drive, Dagsboro, DE 19939 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Washington Crem. 10/15/2004 Laurel, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd. Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ong estive /Medical Due to (or as a con **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) physician Box 68760. pe e ian/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) hysici P.O. I the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate To the Hospitel or Attanding Phyaician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6 Mother (Specify) ARC Home funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 T Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Marks, M.D. 2 Knolls North Drive, Columbia, MD 21045 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/200

Registrar

OCT 1 5 2004

	•	1 - For Stata Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of		Reg.	0001	32786
Physicia /Medic	_	Decedent's Name (First, Middle, Michael	Joseph		Aloi		2. Date of Death Month September	Day Ye	
Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Dea		4c. County of D	
		2232 Kings Hou	se Road		Silver	Spring		Montgon	nery
Funeral		,	5. Sex 7. Ag 12024 2☐ F	e (In yrs. last birthday	If Under 1 Yea Months Days			9.	Birthplace (State or Foreign Country)
Director		219 54 8052	LAW ZUF	54 Yrs.		- House	Sept 1 19		shington, D.C
*	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				and leader on their
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, If e Modical Exercities must be notified at once.	5								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
28a-1	Director	Maryland Montgo 10e. Street and Number	mery	Silver Sp					
De L	Ö				10f. Zip Code		10g.	Citizen of What	Country?
s 23	era	2232 Kings House		* : !! 0		20905		USA	
ltem In	Funeral	11. Marital Status	12. Was Decedent I Amed Forces?		Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		merican Indian, /hite, etc.
5	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 → 1 If Yes, Give Year or Dates:	10	1 ☐ Yes ACKNO	Specify;		Specify:	White
1		15. Decedent's		162 Door	dent's Usual Occu	unation.	400		
) S	Completed	(Specify only highest	grade completed)	(Givi	kind of work done DO NOT use retire	e durina most of wa	orking	o. Kind of Busine	ss/Industry
the	m C	Elementary/Secondary (0-12)	College (1-4or 5	+)				D. 1 . 34	
ther ont, 1	ပိ	17. Father's Name (First, Middle, La		Сощро	cer oper	ations Ma	me (First, Middle, Maid	Cicket M	aster
90 0	00	Wilfred Aloi					a DiBenedet	,	
nati	ပ	19a. Informant's Name/Relationship	n (Tuna Print)	10h Mail	- Add (Ot				
7 is				11111111			ural Route Number, Ci		
ther ther	1 8	Brenda Kay Aloi 20a. Method of Disposition	/ Wife	20b. Place of Disp	2 Kings	House Roa	d Silver S	Spring,	MD 20905
= 60		1 😾 Burial 2 □ Cremation 3		cemetery, cre	matory or other pla	ace)			
jury	1	`4 ☐Donation 5 ☐ Other (Spe		Gate of				lver Sp	
Import any in ance.		21. Signature of Funeral Service Lie	censile				es Rinaldi		
5 2 3		- Fine	elube	S	ilver Sp	ring, 118	300 New Ham	pshire .	Ave 20904
dedical aminer transit the private the private transit the private transit tra	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Oissaes or injury that initiated events resulting in death) Last	b. Metasta Due to (or as a	Pailure a consequence of): atic Cance a consequence of): Rectal Si a consequence of):					Onset and Death 1 Year 1 Year
ed by the attending physicia detached for use as the buri	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal death 3[time of death 5[⊒Ectopic pregnanc			23d. Date of o Month	Day Year
pe pe	9	Part II. Other significant condition:	s contributing to death bu	it not resulting in the t	inderlying cause gi	iven in Part I.	23e. Did tobacc		to the cause of death? Probably 4 Dunknown
should	Completed								
6	m m						24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
, page	ပိ						performed 1 ☐ Yes ₹	? death No 1 ☐ Y	9s 2 No
rector,	Be	25. Was case referred to medical examiner?					ath (Check only one)		
2 70	ို	1 ☐ Yes 2 🛣 🛣 o	Hospital: 1 Inpatier	nt 2 ER/Outpatie	nt 3□ DOA Ot	her: 4 \sum Nursing H	Iome 5 esidence	6 □Other (S)	pecify)
Aller in funeral	ü	27. Manner of Death 1 ★ tural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	f 28c. Iniu	iry at ork?	28d. Describe how in	njury occurred	
2	ati	2 ☐ Accident investigat				Yes 2 □ No			
2 2	ĕI	3 Suicide 6 Could not	28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Street City or Town, Sta	and Number or ate)	Rural Route Number,
ed in by the	Certi	4 Homicide							
ely fill	edical Certification;	29a. Certifier 1 Xertifying	Physician: To the best of aminer: On the basis of and manner state	examination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner and place, and d	as stated. ue to the cause(s)
ely fill	Medical Certi	29a. Certifier 1 Sertifying (Check only 2 Medical Ex	aminer: On the basis of	examination and/or in	h occurred at the ti vestigation, in my	opinion, death occu	rred at the time, date a	o(s) and manner and place, and d Date signed (Mo	ue to the cause(s)
ely fill	edical	29a. Certifier 1 Sertifying (Check only one) 2 Medical Ex	aminer: On the basis of and manner stat	examination and/or in	vestigation, in my	opinion, death occu	rred at the time, date a	and place, and d Date signed (Mo	nth, Day, Year)
To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Sertifying (Check only one) 2 Medical Ex	Aminer: On the basis of and manner star	examination and/or in	29c. Licen	opinion, death occu	rred at the time, date a	and place, and d Date signed (Mo	ue to the cause(s)

24 hours within 2. To the f the ٥

ANA 31. Date filed (Month, Day, Year) 0 8 2004 Registrar

onel

29b. Signature and title of certifier

ua

32. Registrar's Signature

and manner stated.

RUBIO, MO

29c. License number

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

October 06, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 27 Month **Physician** 2004 2:45 P M September David Richard Anderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery Fairland Nursing & Rehab. Center
 7. Age (In yrs. last birthday)
 If Under 1 Year
 If Under 24 Hrs. Months Days Hours Min.
 8. Date of Birth (Month, Day, Year) Jan. 9, 192
 5. Social Security Number 6. Sex 1 → M 2 □ F Birthplace (State or Foreign Country) **Funeral** Louisiana Director 435-24-5199 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, it is Medical Examination to other reaumatic event, it is Medical Examination. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 20904 United States 2102 Fairland Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Airican 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 1 Divorced Year or Dates: American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Dentist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna (Unknown) Adolph Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2202 Richland St., Silver Spring, MD E. E. Bernice Mills/Companion 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/4/2004 Ft. Lincoln Cemetery Brentwood, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signative of Fymeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Physician Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fusions are or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Atrial Falter 1 Yes 2 No 3 Probably 4 Unknown Completed Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 95 page 2 ormaci? 2 🖎 No 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☐ Xio 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completely fi

31. Date filed (Month, Day, Year) State OCT 0 4 2004 Registrar

29b. Signature and title of certine

(Check only one)

Shashank Patel, M.D. 2309 Shorefield Rd., Wheaton, MD Registrar's Signature

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0058962

29d. Date signed (Month, Day, Year)

20902

September 27, 2004

			1 - For State Registrar	State of Maryland		nent of H			iene	32789
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (I) not institution, give, facility Name (Re hability name (hae A	nderstended 45.	50 n City, Town, op Balt	Location of Death	2. Date of Dear Month Septem	Day Yea	204 9. JAM
	Funeral Director		5. Social Security Number 208-30-2048 Usual Residence of Decedent	7. Age (In yrs. la		Inder 1 Year nths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 06/03/		irthplace (State or Foreign Country) ennsylvania
	hours after death with the Maryland tural', or Items 23a or 28a-f show at Examirer must be notified at	I Director	10a. State 10b. County Maryland Wico 10e. Street and Number 105 E. Isabel	mico S	alisbur	Y M. Zip Code	0.01	1	0g. Citizen of What (10d. Inside City Limits 1 🛱 Yes 2 □ No Country?
9000	72 hours after death "natural", or Items 2	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.9 Amed Forces? 1	nes 10 Y	Decedent of Hi , specify Cuba les 2 No	801 spanic Origin? (Spen, Mexican, Puerto Specify:		Black, Wh	white
Maryland 21215-0036	d within 72 jiene. r than "nai	e Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)			of work done a OT use retired,	ation furing most of working ntenance 18. Mother's Name	ng e	16b. Kind of Busines Cleaning Maintena Maintena	g &
ylan	2 should be and Mental Is marked c aumatic ave	To B	Edwin Lowry				Shirle	y Mari	e Johns	
	27 E G		19a. Informant's Name/Relationship (Tyr.) Aleta Davis/si						; City or Town, State, .sbury , MI	
nore	Pages 1 aunent of Heanint: If itam		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ace of Disposition emetery, crematory	(Name of or other place	g)	ate	20c. Location - City of	r Town, State
Baltimore,	permit. Pag Department Important: t any injury o		21. Signature of Funeral Service License	la	Ho I	e and Addres	Funeral	Home	Salisbu Professi sbury,MD	onal Assoc
	Physician /Medical Examiner		23a. Part Enter the disease, or compli- seck, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ence of):	mode of dying	g, such as cardiac o	r respiratory arre	əst,	Approximate Interval Between Onset and Death
8760,	ate be executed thysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, laoding to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						h
.O. Box 6	death certific e attending p d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal of Unknown	death 3□Ectop	pic pregnancy er (specify)			23d. Date of do	elivery Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	tributing to death but not resul	lting in the underly	ing cause give	n in Part I.		_	to the cause of death?
Vital Records,	The law ate has b	e Completed	25. Was case referred to medical				26 Place of Dooth		y prior to ned? death? No 1 ☐ Ye	utopsy findings available completion of cause of s 2 No
of	ding h. Afte fune	Certification: To B	examiner? 1		ER/Outpatient 3[28b. Time of Injury	DOA Cthe 28c. Injury Work 1 □ Y	at 2	ne 5 ☐ Reside		ecify)
DİXİ	To the Hospital or Attenwithin 24 hours after deat To the Funaral Diractor: completely filled in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, fa	ctory, office	2	8f. Location (Str City or Town,	reet and Number or F , State)	lural Route Number,
	To the Hospital or within 24 hours afte To the Funaral Dir. completely filled in I	ledical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my know er: On the basis of examination	vledge, death occu on and/or investiga	rred at the time ation, in my op	e, date and place, a inion, death occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the hwithin 24	Me	29b. Signature and title of certifier	gan		29c. License	334		ed. Date signed (Mon	1
PG PG	2		30. Name and address of person who con Leon N. Palaco	mpleted cause of death (Item :	23a) (Type, Print)	Raven	Blvd -	Baltin	10re, MD	121218
	Sta Registr		31. Date filed (Month, Day, Year) 0CT 0 1 20	32. Registrar's Signatu	ure \not	Spork	2		,	

· 		4	1 - For State Registrar	State of I	Maryland		artmen tificate				lental Hy	giene	The state of the s	32790
ı	Physici	20	1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
1	/Medi		Dorothy	M		Ві	own				Sep	25	-2004	1015M
	Examir	ner	4a. Facility Name (If not institution Levindale Nursi	-	er)				Location of	of Death	,	4c. Cou	inty of Death	pm.
			5. Social Security Number	_	Age (In yrs. la	et hirthday)	If Under	timo	If Under:	24 Hrs	9 Data of Birt		0.834	(0)
Н	Funeral Director		246-54-0696	1□M 2∏F	69	Yrs.	Months	Days	Hours	Min.	8. Date of Birt. (Month, Day Jan 3,	1935	Coun	ace (State or Foreign try) h Carolina
	ō.		Usual Residence of Decedent					l			0411 5,		1,020	
	arylar show	Ä	MD Balti			Town or Lo ltimor							10	0d. Inside City Limits 1 Yes 2 □ No
	he M	Director	10e. Street and Number		Dal	LUIMOI								
	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show alses Exaciling must be routhled at	급	4114 Belle Ave	niie			10f. Zip	215				USA	of What Count	try?
	death ms 23	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S	S. 13. V			spanic Orio	gin? (Spe	ecify Yes or No-		Race - America	an Indian.
9	after or Itea		1 ☐ Never Married 2 ☐ Mari	Armed Force						, Puerto	ecify Yes or No- Rican, etc.)		Black, White, e	
93	irel',	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2	ZIŽI NO	Specify:			Spe	B1	ack
5-("netu	lete		t's Education st grade completed)		16a. Deced (Give	lent's Usua kind of wor DO NOT us	l Occupa k done d	ition <i>Juring m</i> ost	t of worki	ng	16b. Kind of	f Business/Ind	ustry
12	d within 72 hours after death with the Marylan jiene. Ir then "neturel", or Items 23e or 28e-f show The Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	irre. I	Cook	e retirea)	,			Res	stauran	t
Q	Et Ayg		17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,			
Maryland 21215-0036	should be nd Mental marked o	To Be	Robert Duckrey						Sa	rah	Jane Bu	rney		
lary			19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address	(Street a.	nd Numbe	r or Rura	I Route Numbe	r, City or Tov	wn, State, Zip	Code)
	is 1 and 2 of Health a item 27 is other trei		Minnie Brown -	Daughter			- 200		venue		timore,		21215	
Baltimore,	Pages 1 a nent of Hea int; If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Sta	cei	nce of Dispo metery, cren	natory or ot	her place			Date		on - City or Tov	
Iţim	iit. Pa artmen ortent: injury		 4 □ Donation 5 □ Other (S 21. Signatur of Funeral Service 	The same of the sa	Cla	rkton				10-2	-04	Clark	ton, N	С
Ba	pernit. Pages Department of Importent; If i any injury or once.		21. Signatur of Funeral Service	100 dO	00		Name and Centra	ıl Fu	ınera.	1 Ho:		T1		NO
			23a. Part1. Enter the disease, or hock, or heart failure. List	complications that caus	sed the death.						King Dr or respiratory arr		1 -	Approximate
U	Pnysician		Jamediate Cause (Final disease or condition	only one cause on each	1-1	nen	011	lis	e		la.	hi can		Interval Between Onset and Death
	/Medical		resulting in death)	a Due to (or	as a conseque	ence f):)		1//	1 -50	1 00		<u></u>
	Examiner		Sequentially list conditions.	b. Cose	ner	7 6	isle	in.	de	16	lase			7 6 morths
	ed sit	lne	Sequentially list conditions, if any, reading to infimediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	erce of):	2 00	1						7/ma 11
	xecut and	Examiner	that initiated events resulting in death) Last	c. Due to for	as a conseque	ence of):	DO							10/10/14
8760,	death certificate be executed e attending physician and of for use as the burial-transit			d //		,								
9	tificat og phy as the	ledical					-							
Вох	teath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1□Live birth	me of pregnan		Ectopic pre	anancy					Date of deliver	
о. В		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of dea		Other (spe					'	Month [Day Year
Α.	by ac		Part II. Other significant condition	ons contributing to death	hut not result	ting in the ur	derlying ca	uise oivei	n in Part I		23e Did to	Dacco use co	antribute to the	cause of death?
ds,	signed ld be det	d by	Den his	el mu	ules	des	حعن		iriiri carci.				3 ☐ Proba	
COL	w requir been s should	lete	170								24a. Was a			
Vital Records,	sicien: The law s certificate has b irector, page 2 s	Completed									autops	med?	prior to com death?	sy findings available pletion of cause of
tal	(0)	Be Co	25. Was case referred medical		_				26 Place	of Death	1 Yes	No	1 ☐ Yes 2	P□ No
<u></u>	Physicien: r this certificatal director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2□E	R/Outpatient	3 DO	Other	-		ne 5 🗆 Reside		Other (Specify)	
n of	ding Pt h. After th funeral		27. Mann of Death 1 Natural 5 ☐ Pendin	28a. Date of I	njury 2 Da <i>y Year)</i>	28b. Time of Injury	28	c. Injury Work	at	2	28d. Describe ho	w injury occ	urred	
sio	death. ctor: A y the fu	cati	2 Accident investig	gation			М		es 2 🗆 N	10				
Division	l or Attendatter death Director:	Certification;	4 Homicide determ	ined 200. Flace U	etc. (Specify)	ne, tarm, stre	eet, factory,	office		2	28f. Location (Si City or Town	reet and Nur ı, State)	m <i>ber or Rural</i> .	Route Number,
	e Hospitel 24 hours a e Funerel etely filled		29a. Certifier + Certifyin	ng Physician: To the be	st of my know	ledge, death	occurred a	it the time	a. date and	f place, a	and due to the ca	use(s) and o	manner as sta	ted
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examination	on and/or inv	estigation,	in my opi	inion, death	h occurre	ed at the time, d	ate and place	e, and due to t	he cause(s)
	To the h within 24 To the f complete	ž	29b. Signature and title of certifie	1			29c.	License	number	_	2	9d. Date sign	ned (Month, D.	ay, Year)
)			Muye	my my			7	144	181-	+	4	len.	27. 2	2004
			30. Name and address of person	who completed cause of	f death (Item 2	23a) (Type, I	Print)	11	, /2	- 4	01.	6.11	5:11 a-	
			31: Date filed (Month, Day, Year)	1 30 Rani	strar's Signatu	Ire XY	> ~ <	en	~~0°			Nucl	1100	
	Sta Registr	- 0	OCT 1 5 2004	General	4	do	2. 1	,						
			V =	7-	100	- Killer	allo!							

BROLIN DORTHY

		•	For State Registrar	State o	f Marylan		artment of tificate o				giene Reg. No. ()		32791
	ysicia Medic		1. Decedent's Name (First, Middle Robert Cha		ıer					2. Date of Dea Month	eth Day	2004	3. Time of Death
	amin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town	, or Location	of Death		4c. Cou	unty of Death	
			Washington Co					rstown				shingto	
Fun Dire			5. Social Security Number 163-44-0424	6. Sex 1 2 M 2 □ F	7. Age (In yrs.	48 Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birt (Month, Day Jul 15,	1956	9. Birth	place (State or Foreign PA
and	=	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Maryl f sho	a Led	ō	PA Fra	nklin		Wayn	esboro						1 XYes 2 □ No
the 28e	notif	Director	10e. Street and Number	11111		Wayı	10f. Zip Code				10g. Citizen	of What Cou	ntry?
h with	ST PE	<u></u>	904 Park Str	eet.				17268				USA	
deat	ET-18	Funeral	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of Yes, specify Co			cify Yes or No-	14.	Race - Ameri	
13-UU36 n 72 hours after death with the Marylar "neturel", or Items 23a or 28e-f show	arrife	y Fu	1 Never Married 2 X Marr	ied 1 ⊟Yes If Yes, Gi	2⊠No ve		1 □ Yes 21X N			noan, etc./		Black, White, ec <i>ify:</i> V	Mite
5-0036 72 hours af neturel', or	al Ev	d by	3 Widowed 4 Divorced	Year or D	ates:	162 Dans	fanta Haval Osa			1			
72 in 72 in 9	Spa	lete	15. Decedent (Specify only highes	t grade completed)		(Give	lent's Usual Occ kind of work dor DO NOT use reti	iupation 18 <i>during m</i> os 18d)	st of workin	g	166. Kind c	of Business/In	dustry
d 21213-UU36 filed within 72 hours after death with the Maryland Hygiene. uther than "neturel", or Items 23a or 28e-f show	Ned	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	tenance				Apart	ment o	complex
e filed	vent,	BeC	17. Father's Name (First, Middle,	Last)	<u>-</u> -			18. Moth	er's Name	(First, Middle,	Maiden Sun	пате)	``
Maryland d 2 should be file th and Mental H;	otic •	To E	James W. Bakr	er				Ka	thryn	G. Sa	nders		
2 sho			19a. Informant's Name/Relations				ng Address (Stre						Code)
C = W	her to		DArlene K. Ba	ıkner	wife		Park S	t., Wa		oro, P			
Baltimore, bermit. Pages 1 a Department of Hee Importent: If item	or of		20a. Method of Disposition 1 Burial 2 □ Cremation		o	emetery, crer	on Cemet	lace)				on - City or To	
ITIN it. Pa ither rtent	njury		4 □ Donation 5 □ Other (S_i21. Signature of Funeral Service		MO								. Home, Inc.
Departi	any injury or of <u>once</u> .		> Jeanut 1		new		0 S. Br		-				
Physic			23a. Part1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	caused the death each line.			ying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death 3 munth
/Med Exami			resulting in death)	Due to	(or as a conseq	uence of):							
	-	-	Sequentially list conditions,	b	for as a consec								
+ pa _	ınsıt	Examiner	Cause (Disease or injury		(**************************************								
D, exect	rial-tra		that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
Certificate be executed right physician and	ne pri	cal		d									
artifica ing pt	e as t	Med	IF FEMALE:	T									
death cert death cert death cert	for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregna pirth 2 □ Feta	Ideath 3□	Ectopic pregnar				23d.	Date of delive	ery Day Year
. 0 0	thed f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9☐Unkn	nant at time of do own	eath 5∟	Other (specify)						
<u> </u>	deta	V Ph	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the u	nderlying cause	given in Part I		23e. Did to	bacco use c	contribute to the	ne cause of death?
VITAI HECOLIAS, ilcien: The law requires t certificate has been signe	ed bi	d by								124	es 2 N	o 3 🗆 Prot	oably 4 Unknown
CO W rec	should	Completed								24a. Was a		b. Were auto	psy findings available
- 0 E	page 2	шо								autop perfor	med?	death?	mpletion of cause of
Vital P vicien: Th certificate	ctor, p	BeC	25. Was case referred to medical					26. Place	e of Death	(Check only or			22.10
- S S	0	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗷	Inpatient 2 🗆	ER/Outpatien	t 3 DOA	other: 4 🗆 Nu	ursing Hom	e 5 🗆 Resid	ence 6 🗆	Other (Specif	(y)
On C Jing P After t		on:	27. Manner of Death 1 → Natural 5 → Pendin	g 28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	W			8d. Describe h	ow injury oc	curred	
SIC tend teath	the	Icati	2 Accident investig	not be	of taken. At he			☐ Yes 2 ☐		Of Logation /C	treet and Mi	- has as Owe	of Courts Mumber
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After	in by	Certification:	4 ☐ Homicide determ		of Injury - At he ing, etc. (Specif		eet, ractory, offic	8	20	City or Tow		imper or Hura	il Route Number,
spite lours	filled		29a. Certifier 1 Certifyin	g Physician: To the	best of my kno	wledge, death	occurred at the	time, date ar	nd place, ar	nd due to the c	ause(s) and	manner as s	tated.
124 Pul	letely	edical	(Check only 2 Medical one)	Exeminer: On the b	asis of examina ner stated.	tion and/or inv	estigation, in my	opinion, dea	th occurre	d at the time, o	late and place	ce, and due to	the cause(s)
DIVI To the Hospitel or At within 24 hours after or To the Funeral Direct	comp	M	29b. Signature and title of certifie				29c. Lice	nse number		2	29d. Date sig	gned (Month,	Day, Year)
	1		Mushuel	9, on	lound	- MS	1 6	9116	67		10	111.	04
5	8			Nelvemas	K 11	23a) (Type,	29c. Lice Print) Me Acc	.1 (my 6	s 14.	21001	Lun	mp
Re	Sta egistra		31. Date filed (Month, Day, Year)		Registrar's Signa	ture	lon v.	/					
							- Lower						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav 0723M **Physician** be, 22, 2004 Alfred C. Boswell Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 coyes rince Buentwood Windom If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. Days **X** M 2□ F Hours Director 213-54-5583 57 May 7, 1947 Washington, DC Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r than "natural", or Items 23s or 28s-f ahow the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George's **Brentwood** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3405 Windom Rd. 20722 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1969-74 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 **Owner** Architecture other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt iment of Health and Mental Heant; if item 27 is marked officiary or other fraumatic even Alfred C. Boswell Gladys Mae Amos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cameron Boswell/Son 25326 Southeast 36th Ct. Issaguah, WA 98029 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Tremation 3 Removal from State
4 Donation 5 Other (Specify) Fort Lincoln Crematory 10/1/2004 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi F.H. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Atheroscherette Cardioviscular Heart Disea Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate) 20 NO 1 Yes 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1- Natural 5 Pending 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chevely Has SALVADOR 32. Registrar's Signature 31. Date filed (Month, Day, Year State Registrar 30

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or itams 23e or 28a-f show any injury or other traumatic avant, Ire Madical Examinar must be notified at once.

Physician /Medical Examiner To Be Completed by Funeral Director

Please	Type or Prir	nt in Black In	delible Ink. Ensure	All Copies Are	e Legible.	
For State Registrar		aryland / Depa	artment of Health and		_	0.0200
		Ce	rtificate of Death	Reg. f	Vo.	14/93
Decedent's Name (First, Middle, La JAMES ELWOOD BRY				Date of Death Month	Pay 28 2004	3. Time of Death
a. Facility Name (If not institution, given	ve street and number)		4b. City, Town, or Location of Dea	ath 4	c. County of Death	
Doctor's Commun	ity Hospita	a1	Lanham	F	rince Ge	orge's
577-32-9610	Sex 1ÄM 2□F	e (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir	(Month Day Yes	9. Birth Con 1925 Was	place (State or Foreign intry) nington, DC
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
Maryland Prince (Coomacta	Berwyn H	Injohta			1X Yes 2 □ No
10e. Street and Number	George S	Delwyn 1	10f. Zip Code	100.0	Citizen of What Cor	untru/2
5908 Natasha Dri	4		20740-2629			muy:
		Supplied 12			S.A.	iona Indian
 Marital Status 1 □ Never Married 2 ▼ Married 	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	specify tes of No- irto Rican, etc.)	14. Race - Amer Black, White	
3 Widowed 4 Divorced	1 ∑Yes 2 ☐ I If Yes, Give Year or Dates:	WWII	1 ☐ Yes 2X No Specify:		Specify: W	hite
15. Decedent's E (Specify only highest gr	Education rade completed)	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orkina	Kind of Business/lited Stat	•
Elementary/Secondary (0-12)	College (1-4or 5	5+)	Clerical		vy Depart	
17. Father's Name (First, Middle, Las	it)		18. Mother's Na	ame (First, Middle, Maid	_ 	
Henry P. Bryan			Sadie 1	Mae Prout		
19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and Number or F	Rural Route Number, City	y or Town, State, Z	p Code)
Patricia M. Brya	ın - Wife	5908 20b. Place of Dispo	Natasha Drive,	Berwyn Heig	hts, Mary	1and 20740
1 Burial 2 Cremation 3 (4 Donation 5 Other (Spec 21. Signature of Five and Service Log	ify)	Metropoli 22	tan Crematory 10/ 2. Name and Address of Facility Ga 739 Baltimore Avo	asch's Fune:	ral Home,	P.A.
23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a End	the death. Do not entend. **Torge** a consequence of):	cer the mode of dying, such as cardin	4 4	ue	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): Lamulu a consequence of):	ilion			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	rery Day Year
Part II. Other significant conditions		ut not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?
preun	ionia			1 Tes	2□No 3□Pro	bably 4 Dunknown
				24a. Was an autopsy performed?	prior to codeath?	opsy findings available ompletion of cause of
25. Was case referred to medical			26. Place of De	eath (Check only one)		
examiner? 1 Yes 2	Hospital:	ent 2 ER/Outpatier	nt 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Spec	fy)
27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time o		28d. Describe how in		
1	on	, roally injury	M 1 Yes 2 No			

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be execu

Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

State Registrar MEHRU MASTER, MID
31. Date filed (Month, Day, Year)
OCT 0 1 2004

alster

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



MM

29c. License number

D050514

29d. Date signed (Month, Day, Year)

20737

9/30/04

		•	1 - State	artment of Health and Menta rtificate of Death	7° 0° 0
			1. Decedent's Name (First, Middle, Last)		Reg. No.
	Physicia	an		Mo	nth Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	tember 26 2004 0520 ^M 4c. County of Death
	Examin	er	,		
			Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Annapolis If Under 1 Year If Under 24 Hrs. 8 Dat	Anne Arundel e of Birth 9. Birthplace (State or Foreign
	Funeral Director		1 □XM 2 □ F Yrs.	Months Days Hours Min. (Mo	onth, Day, Yeer) Country)
			219-11-6603 31 IIIs. Usual Residence of Decedent	Nov	. 22 1972 Maryland
	fand ow		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	Many 1 sh	to	Maryland Anne Arundel Annapol	ia	1 ∑Yes 2 □ No
	the r28a ncti	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	3a o		108 Dogwood Road	21403	USA
	ma 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Ye	s or No- 14. Race - American Indian,
က	or ite	교	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	If Yes, specify Cuban, Mexican, Puerto Rican,	
93	hours after death with the Maryland tural', or Itema 23a or 28a-f show al Examirer must be notified at	ξ	3 ☐ Widowed 4X Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:	Specify: Black
21215-0036	172 hours after death with the Marylan "natural", or itema 28a or 28a-f show viical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
21	d within 72 ho jiene. r than "natur it e Medical	adr.	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
21	filed wi Hygien ther th	5	12th $2\frac{1}{2}$ Ele	ctrician	Local Union #26
p	\$ 5 5 6	Be (17. Father's Name (First, Middle, Last)		Middle, Maiden Sumame)
Иa	should by the Menta s marked umatic ev	ပ	Robert J. Brown	Virgie	
Maryland	2 2 2		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)
	1 and 2 Health tem 27 Sther tra	3		Dogwood Rd. Annap	
ore	of H of H if iten	13	20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of Date matory or other place)	20c. Location · City or Town, State
Baltimore,	permit. Pages of Department of Humbortant: If ite any injury or of once.		`4 □Donation 5 □Other (Specify) Lakemon	t Mem. Gardens 10/	1/04 Davidsonville, Md
alt	permit. Departr Imports any inju			2. Name and Address of Facility	rtuaru D A
<u> </u>	89789		Lavy & face Moo 483 8	m. Reese & Sons Mo 21 West St. Annapo	lis, Má. 21401
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respir	Interval Between
	Physician		Immediate Cause (Final disease or condition	nel filmes	Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	Tall Tall Tall	
	Examiner		Sequentially list conditions, b. Severe 1-1	to	
A	p =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
6	nd	Examiner	that initiated events c.		
, 0,	be executed sician and burial-transit	Ĕ	resulting in death) Last Due to (or as a consequence of):		
8760,	ate hy:	dical	d		
9	eath certific attending p	a l	IF FEMALE:		
Вох	ath co	an/		Ectopic pregnancy	23d. Date of delivery Month Day Year
0	at the dea by the a tached for	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 [Other (specify)	
<u>P</u> .	that the	Ph)	Part II. Other significant conditions contributing to death but not resulting in the u	anderhing cause given in Part I 23	e. Did tobacco use contribute to the cause of death?
JS,	ires t signe	by	Taken. Other arguments contained contributing to document for the containing in the	indonying dadd given in ranti.	1 Yes 2 No 3 Probably 4 Unknown
Records,	w require been si should b	Completed			
ec	e law has b	npje		24	a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
		Cor		1	performed? death?] Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
Vital	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)
of	Physician: this certific ral director.	မ	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatie		☐ Residence 6 ☐ Other (Specify)
		lon:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury	Work?	escribe how injury occurred
Sic	ttendi death. ctor: A / the fu	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 No	cation (Street and Number or Rural Route Number,
Division	after death after death Director: /	Certification;	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	City	y or Town, State)
_	pital ours a eral I		29a. Certifier 1 (Certifying Physician: To the best of my knowledge, dea	th pecurred at the time, date and place, and due	to the equipment of stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.		
	o the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	⊢≯⊢ŏ		2100	Du 100 21	9/22/
	6		30. Name and address of person who completed cause of death (Item 23a) (Type	Print 1 0 A da da sate at	1/ 4/04
	5		20. Name and address of person who completed cause of death (nem 25a) (Type	A ALARISEN	7.14-1
É	Sta	ite	31. Date filed (Month, Day, Year) 32 Pegistrar's Signature	mapols "")	U' 101
	Registr		SEP 2.9 2004	Lo.	

		-	For State Registrar	State of	Marylan		artment o			and M		giene Reg. No.	nn.	32705
	Physicia	an	Decedent's Name (First, Midd	(e, Last) 10 B	llas		······································				2. Date of De Month Octobe	ath Dav	2004	3. Time of Death 8:05 P M
	/Medic Examin		4a. Facility Name (If not institution	on, give street and numb	per)		4b. City, To	wn, or l	Location o	of Death			County of De	ath
			Anne Arundel M	edical Cent	er		Annap						ne Aru	nde1
	Funeral		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F		last birthday)	If Under 1 \ Months D	ear ays	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da 12/18/	h Y Year)	9. Bi	irthplace (State or Foreign Country)
	Director		232-58-0551 Usual Residence of Decedent	X 2	- 6	66 Yrs.					12/18/	1937	We	St Virginia
	land ow		10a. State 10b. Count	/	10c. Cit	ty, Town or Lo	ocation				· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Mary -f sh	to	MD Anne	Arunde1	Anr	napolis	3							1 □XYes 2 □ No
	r 288	lrec	10e. Street and Number				10f. Zip Co					10g. Citiz	en of What C	Country?
	th wil	by Funeral Director	98 Summerfield	Drive			21	403				U.S.	. A .	
	r dea	nei	11. Marital Status	12. Was Deced Armed Forc	es?	.S. 13.	Was Deceden If Yes, specify	t of His Cuban	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	- 1	 Race - Arr Black, Wh 	nerican Indian, lite, etc.
36	s afte	Ϋ́F	1 ☐ Never Married 2 ሺ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give			1 □ Yes 2	No	Specify:				Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ane. then "naturel" or Items 23a or 28a-f show the Medical Examiner mast be indiffied at	edt	15. Decede	nt's Education		16a. Dece	dent's Usual C	Occupa	tion			16b. Kin	d of Busines	s/Industry
212	hin 72 n "nu	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4	or 5+)	(Give life.	dent's Usual C kind of work of DO NOT use i	done du retired)	uring most	t of worki	ng			
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pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle	, Last)				,			(First, Middle,		Sumame)	
yla	Men Marke marke	၉	Mike Ballas	ahia (Time Bried)		40h Maille	- Add (C				Stathak Route Numbe		Town State	Zin Codo)
Maryland	d2st than than traun		19a. Informant's Name/Relation Betty P. Balla								apolis,	-	21403	Zip Code)
	Heal Heal tem 2		20a. Method of Disposition		20b. F		osition (Name matory or othe		. 1	С	ate		ation - City o	r Town, State
OE I	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (ale		Memor		- 111)/8/: dens	2004	Annaj	polis,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If item 27 is marked other then "naturel; or Items 23a or 28a-f show appring to other traumatic event, the Medical Examinet mast be rediffed at any injury or other traumatic event, the Medical Examinet mast be rediffed at ances.		21 Signature of Funeral Service		A		2. Name and A				Bowie,	Mory	land 2	0715
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	or complications that cau	used the deat	-							Lanu Z	Approximate
	Pnysician		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	-a. Liv	es f	ailu			eles-				2	Interval Between Onset and Death
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387	icate l physi s the t	dlcal		d										
9 XC	death certific e attending pl ed for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								2:	3d. Date of de	elivery
Вох	death a atter d for u	iclar	in the past 12 months?	4☐Pregnar	h 2 ∐ Feta nt at time of c		⊒Ectopic preg ⊒ Other (s <i>peci</i>						Month	Day Year
P.0		hys	9 Unknown	9□ Unknov	vn									
	es tha	by P	Part II. Dther significant condit			sulting in the u	ndertying caus	se give	n in Part I.					to the cause of death?
ord	w requir been si should I	ted	CO1. +15-	Asdem	-Le			_			10	Yes 2□	No 3□F	Probably 4 Anknown
Records,	e law has by	Completed									24a. Was autor	sy	24b. Were a prior to death?	autopsy findings available completion of cause of
al F	Th ate pag										1 Yes	rmed?	1 ☐ Ye	
Vital	Physicien: Th this certificate ral director, pay	o Be	25. Was case referred to medic examiner? 1 Yes	Hospital	Batient 2□	ER/Outpatier	2C DO4	Othe			(Check only o		CO.b /C	
of		$\vdash $	27. Manner of Death	28a. Dat of	Injury	28b. Time o		Injury	4 🗀 140		ne 5 🗆 Resid 28d. Describe l			өспу)
ion	Attending F r death. ector: After by the funera	atloi	1 Natural 5 Pend 2 Accident inves	ing (Month) tigation	Day Year)	Injury	м		? ′es 2!	No				
Division	in the	Certification;	3 Suicide 6 Could 4 Homicide deter	mined 288. Place 0	f Injury - At h g, etc. <i>(Specil</i>		reet, factory, o	ffice		1	28f. Location (3 City or Tox		Number or P	Rural Route Number,
	Hospite 4 hours Funere	edical C		ing Physician: To the bas	is of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certif	fer DNO			29c. L	icense	number	191	.1	29d. Date	signed (Mor	nth, Day, Year)
10	(5)		30. Name and address of perso	n who impleted cause	of death (Iter	m 23a) (Type,	Print) A	, ,	01.	ho	1 lich	Tr	iter	/
1			31. Date filed (Month, Day, Yea	estick /	gistrar's Signa	V) v d		VC	W V	IK.S	1104			
	Sta Registr	12		2004	gistiais signi	k for	de							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** NELLIE LOUISE BLUMENAUER October 3, 2004 11:24 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month Day, Year)
May 10, 1952 Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Months Days Min 1 □ M 2 🛱 F 214-28-5137 72 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Interest of Health and Mental Hygiene. Interest of Items 23e or 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. Counts ir then "neturel", or Items 23e or 28e-f show the Medical Examinar must be notified at Yes 2 No Funeral Director Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Birmingham Court 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: ρ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bank 12 Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nellie Haifleigh Alvie H. Cecil, Sr. ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permil. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu G. Leonard Blumenauer (Husband) 307 Birmingham Court, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 10/7/04 Frederick, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Frvice Lice 22 Name and Address of Eacility & SON FUNERAL HOMES, P.A. MI NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physician and a be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Inpatient 2 ER/Gutpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier MDans Sar OUSE AVE, Frederich 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 212, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended, #31, 7CHD, For 09/27/2004, skl State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Amended, #5, F. H, TCHD, 09/27/04 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Brown Year Shyteke 1910 M September 21,2009 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner John Hopkins Hospital <u>Baltimore</u> If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 8 **Funeral** Days 1**5** M 2□ F Months Yrs. Director 218 61 3 Sept.4,2001 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 No Maryland Wicomico Fruitland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Popular Street, Apt. 103 21826 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify. 3 Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never worked Never worked uould be file. Ith and Mental Hvo. 7 Is mark 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be ment of Health and Menta tent: If Itam 27 is markad Calvin Brown Anissa Lof1and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anissa Lofland 302 Popular St., Apt.103, Fruitland, Maryland 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Pagé Department d Important: If any injury or gree ' 4 ☐ Donation 5 ☐ Other (Specify) 09-25-2004 Federal Hill Cem. Federalsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 516 S. Main Street, Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asphyxia 11 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) hours Examiner obstruction by howay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit 20 BY MEDICAL EXAMINER nding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 3 Ectopic pregnancy CERTIFY ATT 11 POPROT 5 Other (specify) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death the f 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiopulmanan amest 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner?

1 res 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After hot dog 1 Natural 5 Pending Child choked on hot dog 281. Location (Street and Number or Rural Rout Number, City or Town, State) 302 Poplar street Fruitland Mayland 21826 September 21 2004 0815 M 1 ☐ Yes 2 ☑ No investigation after death Director: 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide filled in by 4 Homicide HOME within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 600 North Welfe street (Johns Hoplans Hospital) September 21, 2004 30. Name and address son who completed cause of death (Item 23a) (Type, Print) Lennifer Elizabeth Tucker Maryland 21257 Baltimore 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State SED Registrar DHMH 17 Rev 1/2001

ORIGINAL

9:08PM	
4-37-04	
Cofino, Angeles	

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			For State Registrar	State of N	faryland / Depa	rtificate of			Reg. No. () () ()	32798
	Physici /Medio		1. Decedent's Name (First, Middle, Angeles Cof:	,		,		2. Date of Dea Month Septemb	Day Year er 27, 200	3. Time of Death 4 9:08 P M
H	Examir Funeral Director		4a. Facility Name (If not institution, Suburban Hosp. 5. Social Security Number 218-56-5720	ital	r) Nge (In yrs. last birthday) 95 Yrs.	4b. City, Town, or Bethes If Under 1 Year Months Days	Location of Death da If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Sept. 2	(Year) C	
To control of	show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2x No
d d	3e or 28a-1	I Director	Maryland Montgo 10e. Street and Number 4528 Everett		Kensing	10f. Zip Code 20895			10g. Citizen of What C	ļ
2-0000	half Hygiene. at the maintain, or liems 23e or 28e-f show event, the medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	5? ₫No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔯 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
0-CIZI:	ne. nen "natur e Medicel	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work !)	sing	16b. Kind of Business	:/Industry
יו ק	intal Hygiene.	Be	12 17. Father's Name (First, Middle, La Jose Cofino	ast)	Hor	memaker	18. Mother's Nam	e (First, Middle, na Pere		
	Ith and Mental is 27 is marked or reumatic eve	은	19a. Informant's Name/Relationshi	p <i>(Type, Print)</i> pez/ Daught			and Number or Rur	al Route Numbe	r, City or Town, State,	
73 _	Department of Health importent: If item 27 any injury or other trooping.		20a. Method of Disposition 1 Sa Burial 2 Cremation 4 Donation 5 Other (Special Service Li	ocify)	Gate of Cemete	matory or other place Heaven ry 2. Name and Addres rancis J.	e) Septe 2 as of Facility Collins	Funeral	Home Inc.	ing, Marylar
P	nysician /Medical xaminer	ier	23a. Part1. Enter the disease, or or shock or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Myocare Due to (or a	ed the death. Do not ent	er the mode of dyin				Approximate Interval Between Onset and Death 3 Days 3 Days
dot ou		edical Examine	cause. Enter underlying Cause (Lines) that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):	estion				Unknown Unknown
\ \frac{1}{2}	e attendii	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2√No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	an signed by	by	Part II. Other significant condition	s contributing to death	but not resulting in the u	nderlying cause give	en in Part I.		bacco use contribute to	o the cause of death?
		Completed						24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of 2 No
5 8	ter this ce	ilon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√2 No 27. Manner of Death 1 ☒Natural 5 ☐ Pending	Hospital: 1 👿 Inpa' 28a. Date of In (Month, D	jury 28b. Time of	f 28c. Injury Work	4 Nursing Ho	me 5 Reside	ne) ence 6 □Other (Spe ow injury occurred	ocify)
DIVISION	ter deat irector: n by the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e Place of I	njury - At home, farm, str etc. (Specify)			28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
To the Housist	within 24 hours at To the Funerei D	Medical ((Check only 2 Medical E.		it of my knowledge, death of examination and/or in stated.	vestigation, in my or	pinion, death occur	red at the time, d	ate and place, and due	to the cause(s)
, E	Nith Control	2	7000	imD	1 1 (1)	29c. License		2	9d. Date signed (Moni	
	Sta	10	30. Name and address of person w Natasha Lisa 31. Date filed (Month, Day, Year)	Chen, M.D.		cal Cente	r Ddrive,	, Rockvi	lle, MD 20	850
E	Regist		SEP 3 0 20			Sparks				

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day Year) 2004 OCT

cere

30. Name and adverse of person who completed cause of death (Item 23a) (Type, Print)

James Catevenis, 3001 HOspital Drive Cheverly, MD. 20785 M.D.32 Registrar's Signature

30318

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 24, 2004 **Physician** 1:30pm M Antoinette Joanne Cash /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bethesda Under 1 Year | If Under 24 Hrs. Montgomery National Institutes of Health 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F Yrs. 11Washington, D.C. Director 436-23-1934 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location s 23a or 28a-f show ast tw notified at 1 Ves 2 □ No Washington D.C. Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 3727 Oakview Terrace N.E. 20017 USA or Items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status other traumatic event, the Medical Examiner: Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Specify: Black 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 2 yrs. Elementary/Secondary (0-12) Social Worker Womens Collective 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Hammon Steven C. Cash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3710 34th. Street Mt. Rainier, MD 20712 Ella Ebron/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 = 6 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Mt. Olivet Cem. 10-5-04 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee once 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months2 4□Pregnant at time of death 5 Other (specify) Yes 2 DNo 9 Unknown 9 🗌 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pertormed 2 No this certificate 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 □Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Certification: To 1 TYes 2 1 3□ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

10 Center Drive, Bethesda, MD 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atoinette Williams
31. Date filed (Month, Day, Year)
007 0 1 2004

04-063/6 cm	_	For Unpend Item 1						•	Are Legible giene	e.			
					Ce	rtificate of	Death			32801			
Physician /Medica	n	1. Decedent's Name (First, Middle, Las John Drayton Co	•	on Jr				2. Date of De Month October	Day Ye	3. Time of Death 10:12 P ^M			
Examine		4a. Facility Name (If not institution, give		mber)			or Location of Dea		4c. County of I				
		Malcolm Grow Hos		7 Ann //m .	ero la et biethele.		Air Ford			George's			
Funeral Director			ex 2□ F	7. Age (in)	yrs. last birthday Yrs.	Months Days		8. Date of Bird Month, Da April	y, 9, 1945	Birthplace (State or Foreign Country) Washington DC			
land	- 1	Usual Residence of Decedent 10a. State 10b. County		10c.	. City, Town or L	ocation				10d. Inside City Limits			
he Mary 28a-f she	ector		Georges	s	Fort Wa	shington			40 Cirio a statio	1 ⊊Yes 2 □ No			
a or 3	בֿ	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?			
leath ns 23	era	7411 Harpers Dr:	12. Was Dece	edent Ever i	n U.S. 13	Was Decedent of h		Specify Yes or No	USA - 14. Race - /	American Indian,			
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28s-f show ont, the Medical Exercine for male to rodifie a single.	by Funeral Director	1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	Armed Fo	rces?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		rto Rican, etc.)	Specify:	White, etc.			
2 hou	ted ted	15. Decedent's Ed	ducation	04-	16a Dec	edent's Usual Occup	pation		16b. Kind of Busin	ess/Industry			
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212 ed with giene. ier than	5	11			Sta	tion Mana			Dute Number, City or Town, State, Zip Code) Washington MD 20744 20c. Location - City or Town, State 1/2004 Brentwood, MD Lincoln Funeral Home ad; Brentwood MD 20722				
⊆ 8 m 5 ≥	lo Be	17. Father's Name (First, Middle, Last) John Drayton Cul		n Sr.				me <i>(First, Middl</i> e, l Lewis	Maiden Sumame)				
2 sho and Is me sume		19a. Informant's Name/Relationship (Type, Print) Aretha Culbertson - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 7411 Harpers Drive; Fort Washington MD											
and and lealth m 27	-		on - Wii					Fort Wash					
DOTE ges 1 if its or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐		State		osition (Name of ematory or other pla							
Baltimore, semit. Pages 1 at Department of Hea mportant: If them my Injury or otha	i	4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licer		F	A STATE OF THE STA	coln Crer 2. Name and Addre							
Baltimore, Me permit. Pages 1 and 2 Department of Health at Important: if Item 27 is any Injury or othar trau		_	Klober	0	-								
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687 ficate p phys	edic		d						-				
Box 687/leath certificate attending physical for use as the total attending physical for use as the total attents.	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pre		□Ectopic pregnanc			23d. Date of	delivery			
IS, P.O. B res that the death igned by the atter be detached for	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time		☐ Other (specify) _			Month	Day Year			
s that s that need to e deta	D P	Part II. Other significant conditions of	contributing to de	eath but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribu	te to the cause of death?			
Cords w require been sig								101	'es 2□No 3□	Probably 4 Unknown			
Division of Vital Records, to Attanding Physician: The law requires ta after death. Director: After this certificate has been signed in by the funeral director, page 2 should be to the state of the s	Completed							24a. Was autop perfo	an 24b. Wer sy prior med? deat	e autopsy findings available to completion of cause of h?			
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Division of Vital Records, P.O. Box 687 Hospital or Attanding Physician: The law requires that the death certificate Phours after death. Funeral Director: After this certificate has been signed by the attending phys tely filled in by the funeral director, page 2 should be detached for use as the	Certification;	3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
DIVIS To the Hospital or Attivition 24 hours after de To the Funeral Directs completely filled in by the	Medical		miner: On the bi						cause(s) and manne date and place, and				
To th withir To th comp	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo								fonth, Day, Year)				
		▶ UneIZ					.C.M.E.		October 0	3, 2004			
UR			UB10,	, MD	1		Street, E	altimore	, Marylan	d 21201			
State Registra		31. Date filed (Month, Day, Year) OCT 0 8 200	4 See	Registrar's S	ignature	whi .							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ΑM September 30 2004 0934 Spicy May Cline /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Cecil Union Hospital Elkton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT 2, 193 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs. 73 Virginia Director 228-42-3015 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Virginia Tazewell North Tazewell 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 236 2801 Adria Road 24630 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Items : 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "neturel", or 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.
?7 is marked othar then "traumatic evant, the Me. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any linity or other traumatic event 9008. Alice Blankenship Jefferson Sidney McGraw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 49 Forest Glen Lane, North East, Maryland 21901 Lee Cline/Son 20b. Place of Disposition (Name of cometery, crematory or other place) Mountain Valley Memorial Cemetery October 2, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Big Rock, Virginia 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signiture of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Disease Pnysician unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Altoroscleratio Coronary Actory disease 1 Yes 2 No 3 Probably 4 Unknown been si Diabeter Mellitus 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Renal Mass 2 No 1 🗌 Yes of Vital 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 ☑Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To tha Hospital within 24 hours a To tha Funaral C 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) achder-S. MD. 9,30,04 1)00233222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elector MD21921 S. SACHDEN MD. 118North SI Sente 3B 3 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 3 0 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 12:02 PM September 26,2004 John Edward Cooper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County Cecil E1kton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Jan. 4,1952 Director 52 West Virginia 216 54 9554 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Peges 1 and 2 should be filed within 72 hours after deeth with the Marylen ment of Heatth and Mental Hygiene.
ant: If Item 27 ie merked other than "natural", or Items 23a or 28e-f ehow ury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes AOXNo Directo Maryland Cecil ELkton 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 258 Justice Way 21921 **United States** Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Completed by Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Lineman Conectiv 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Adam Cooper Grace Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois M. Cooper/Wife 258 Justice Way, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges Department of H Important: If It any injury or o once. 1 □ Burial 2 X Cremation 3 □ Removal from State October 3, Mayerdale Crematory Newark, Delaware *4 □ Donation 5 □ Other (Specify)
21. Signature expect License 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Infave HON **Physician** MYOCARCIAL resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Box 68760, Physician/Medical as t the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. ģ Division of Vital Records. 3 Probably 4 Unknown 1 TYes No should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as e autopsy certificate ha 1 ☐ Yes 2 000 1 ☐ Yes 2 ☐ No or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X AOLYE 2 this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Injury 5 Pending To the nuspies after death.

To the Funeral Director: All 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 33510 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reoules TMOHY SNNE 31. Data filed (Month, Day, Year) SEP 3 n 2004

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 26, 2004 Physician 1:25 A M Carmen Rosa Chauca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges Gladys Spellman Speciality Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, You Dec 30, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 578-74-9798 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Fairfax Alexandria 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 4520 King Street #806 22302 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 XYes 2 No Specify: Peruvian Specify. þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other th any injury or other traumatic event, ITEM ONCE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andres Zerpa Delfina Olivares 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4520 King Street #806 Carmen Martin- Daughter Alexandria VA 22302 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) Columbia Garden 10/1/04 Arlington, VA 22. Name and Address of FacilityEverly Community Funeral Care 21. Signature of Funeral Service Licensee Þ 6161 Leesburg Pike Falls Church VA 22044 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 Days **Physician** Urosepsis /Medical Due to (or as a consequence of): **Examiner** 10 Years Diabetes Mellitus Type 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner spital or Attending Physician: The law requires that the death certificate be executed tours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed? Cardiovascular 2⊠ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 🔀 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedican examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State

Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) OCT 0 4 2004

(Check only one)

29b. Signature and title of pertific

6130 Landover Road Dr. Revathy Myrthy Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

D16273MD

29d. Date signed (Month, Day, Year)

10/4/04

Cheverly MD 20785

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 6:45 P M September 26, 2004 John Lucius Clark /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1**∑**M 2□ F Director 83 Oct. 9, 1920 New York 160-24-8778 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evanther must be notified at 1 Yes 2 No Directo Maryland Montgomery Montgomery Village 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19310 Club House Road #506 20886 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. t X Yes 2 □ No If Yes, Give Year or Dates:WWII 1 Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coltege (1-4or 5+) Elementary/Secondary (0-12) 5+ Market Researcher Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill trent of Health and Mental Hrant: If Item 27 is marked offillury or other traumatic even Be Grace Whitenack Ralph Lucius Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type, Print) Carol Ann Clark/wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition September cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or 30, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Odenton, Maryland Coing Home Cremation Service 21. Signature of Funeral Service Licensee P.O. Box 784 21029 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Subdural Hematomas mo ome /Medical Due to (or as a consequence of): Examiner Closed Head Injury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Fall Due to (or as a consequence of): 0 30 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be ģ Coagulopathy 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Cardiac Arrhytmia has autopsy performed? this certificate 2□ No 1 Yes 1 ☐ Yes 2 XNo director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 XYes 2 No : After this 28a. Date of Injury (Month, Day Year) 9/25/04 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 9:30 A M Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2X No fall down stairs 2 XAccident after death Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State Montgomery Vil., MD 19230 Montgomery Village Ave 6 Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide shopping center sidewalk 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Symmetry On the basis of examination and/or investigation in my opinion death accurred at the cause (s) and manner as stated. 29a. Certifier Medical Medical-Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D42135 September 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike #G100 Rockville, MD 20852 Dany Westerband M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 1 2004

32. egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- State RegistrarAmend#5, perFH, FCHD, SL, 10/8/0 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCTOBER Year **Physician** EUGENE CLARENCE CARLISLE 2:38 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr. | 1, 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 6. Sex 1f 1 M 2 □ F **Funeral** 80Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23e or 28a-f ehow traumatic event, tre Madical Exemple restricts be redified at 1 Yes 2 □ No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code WIT 21701 1201 Pinewood Drive U.S.A. death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Trucking & Garage Elementary/Secondary (0-12) College (1-4or 5+) Owner & Operator Business 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eugene C. Carlisle, Sr. Helen V. Colbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) L. Marie Carlisle (Wife) 1201 Pinewood Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 permit. Page Department of Important: If any injury or once. Mt. Olivet Cemetery 10/4/04 Frederick, Maryland 22. Name and Address of Facility & SON FUNERAL HOMES, P.A 21. Signature of Funeral Service I 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ruptural ahdomid acrtic Physician 30 m11 /Medical Due to (r as a consequence of) Examiner. Sequentially list conditions, Sequentially list condition any, leading to immediacuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Semo Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes after death.

Director: After this certific:
In by the funeral director, To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 □ DOA 2 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 009689 04 corre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West 9th Street, Frederick, Maryland 21701 Austin Pearre, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State coaks 0 5 2004 Registrar

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	Physicia		1. Decedent's Name (First, Middle MARGARET R		LANCE						2. Date of Death Month Oct 2	Day 2004	Year	3. Time of Death 03:10 M
	/Medic Examin		4a. Facility Name (If not institution			nber)		4b. City, Town, o	r Location o	of Death		4c. County	of Death	051.0 1
н	LAdilliii	GI	Kline Hospic	e Hou	ıse			Mount	Airy			Free	deric	
	Funeral Director		5. Social Security Number 219-20-4680	6. Sex 1 □ N	4 2 X F	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, June 8,			place (State or Foreign ntry) yland
	and and	}	Usual Residence of Decedent 10a. State 10b. County			10c. Ci	ty, Town or Lo	ocation					1	Od. Inside City Limits
	Mary -f sho	ţō	Maryland Howar	d		Mo	ount Ai	rv						1 ☐ Yes 2 🛣 No
	h the or 28s	jec	10e. Street and Number	u				10f. Zip Code			10	g. Citizen of V	What Cou	ntry?
	23a c	rain	640 West Water	svil	le Ro	ad		2177					S.A.	
	ltems	Funeral Director	11. Marital Status		Armed Fo		J.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Ori an, Mexican	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
36	irs aft		1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced		1 ∐Yes If Yes, Giv Year or Da	9		1 ☐ Yes 2 📉 No	Specify:			Specify	/: B1	ack
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, I'm Medical Evantiner must be rediffed at	Completed by	15. Deceder	t's Educa			16a. Dece	dent's Usual Occup	ation	t of workin		16b. Kind of Bu	usiness/In	dustry
218	ithin 7	nple	(Specify only higher Elementary/Secondary (0-12)	si grade (College (1	-4or 5+)		kind of work done DO NOT use retired	d)	O HOINII				
	lygien her th		12 17. Father's Name (First, Middle,	/ ant\			Home	maker	19 Mothe	r's Nama	(First, Middle, N	taiden Suman		Home
Maryland	12 should be fited within n and Mental Hygiene. 7 is marked other than "reumatic event, I'm Me.	Be	Roland M.		rsey					Alice	40.655	orsey	(6)	
Z	s 1 and 2 should I Health and Men item 27 is marke other treumetic	ဥ	19a. Informant's Name/Relations				19b. Maili	ng Address (Street					State, Zip	Code) 21771
Š	alth al		Hubert E. Mulke	y -	P.R.			01d Bar						faryland
e,	of Her	h à	20a. Method of Disposition	3 🗆 🗆	noval from	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	Di	ate 2	20c. Location -	City or To	own, State
<u><u>Ĕ</u></u>	Pagement ent: It oury o		1 ☐ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (5	pecify)	noval nom	Met	tropoli	tan Crem	atori	um 10	/04/04	Alexa	ndria	, Virginia
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		21. Signature of Pineral Service	Lick nsee	31 /	-	d 03	2. Name and Addre	ss of Facilit leswo :	rth F	.A., Fu	neral 1	Home	
8760,	Cate be executed /Medical Examiner bhysician and bhysician and sthe burial-transit the burial-transit	ical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c. d.	Due to (STR or as a consec Hyp	quence of):	scon)						Interval Between Onset and Death
P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2∜ No 9 □ Unknown	230	1 Live b	come of pregninth 2 Tet ant at time of own	aldeath 3[□Ectopic pregnanc;	/		-		te of delive	ery Day Year
	uires that n signed by ild be deta	þ	Part II. Other significant conditi	ons contr	ibuting to de	eath but not re	sulting in the u	ndertying cause giv	en in Part I.		23e. Did tob	40	ribute to ti 3 ☐ Prot	he cause of death?
Records,	The law requir cate has been si page 2 should l	Completed									24a. Was ar autops perform	/ led?	prior to co death?	psy findings available mpletion of cause of
Vital	icien: Th certificate rector, pag	Be Co	25. Was case referred to medica	ıl					26. Place	of Death	(Check only one		I □ Yes	2 No
o	fune fune	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	- !		inpatient 2 Coof Injury th, Day Year)	ER/Outpatie 28b. Time o Injury	f 28c. Injui Wor	4 🗀 140	2	ne 5 Reside 8d. Describe ho		er (Specit	to spice
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ft	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined	28e. Place buildi	of Injury - At I ng, etc. (Spec	nome, farm, st ify)	reet, factory, office		2	8f. Location (Str City or Town		er or Rura	al Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (r: On the b			h occurred at the til vestigation, in my o	pinion, dea	th occurre	d at the time, da	te and place,	and due to	the cause(s)
)	Tot withi Tot	Σ	29b. Signature and title of certific	54	_			29c. Licens	1309	1	29	Od. Date signed	d (Month,	Day, Year) Y Nele MD
_	5		30. Name and address of person	TA	101	MN	2	Print) ROI TO	u t	tous	e Ave	. Fr	edes	nek MD
	Sta Regist		31. Date filed (Month, Day, Year			legistrar's Sign	ature	Spar	Ks)					

		1 - For Amend Items Registrar 1. Decedent's Name (First, Middle, L						2. Date of Death	g. 1100	3. Time of Death
Physic /Medi		Gary Lee	Diffender	fer				Septembe	Day Yee er 30, 20	l M
Exami		4a. Fecility Name (If not institution, gi	ve street and number)		4b. C	ity, Town, or Local	tion of Death		4c. County of De	
_		Memorial Hospita 5. Social Security Number 6.		In yrs. last birth		aston	nder 24 Hrs.	8. Date of Birth	Talbot	
Funeral Director		219–40–5781	1 [X] M 2 □ F	Yr	Mont			(Month, Dey, Y	40.00	irthplace (State or Foreign Country)
		Usual Residence of Decedent		62				June 12,	. 1942 м	aryland
Maryland -f ehow	7	10a. State 10b. County		IOc. City, Town o						10d. Inside City Limits
the Maryla 28a-f ehov	ecto	Maryland Carol	ine	Pre	ston					1 ☐ Yes 2 反 No
를 하 및	Funeral Director	10e. Street and Number 7798 Westerly Dr.	i vo		101.	Zip Code 21655			g. Citizen of What (•
death w	lera	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was De	cedent of Hispanic specify Cuban, Mes	Origin? (Spe		Inited St	ates nencan Indian,
		1 ☐ Never Married 2 ☑ Marned	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		_			Rican, etc.)	Black, Wh	nite, etc.
10 - 7	d by	3 Widowed 4 Divorced	Year or Dates:		1 🗆 🕇 9	s 2 ∑ No Spe	crry:		Specify: United	d States
n 72	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(0	ive kind of	Isual Occupation work done during Tuse retired)	most of working	ng 16	b. Kind of Busines	s/Industry
r then	дшо	Elementary/Secondary (0-12)	College (1-4or 5+)		ew Le	,		-	17 '	
Hyg othe	a	17. Father's Name (First, Middle, Las	1)		ew re		other's Name	(First, Middle, Ma	lectric (& Gas Co.
T to D	To B	Ralph Edwa	ard Diffende	erfer			Velma	Ruth Fo	lkenroutl	1
s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship			lailing Addr	ess (Street and Nu			City or Town, State,	
and ealth m 27		Joan M. Diffende	rfer Wife		8 Wes	terly Dri	ve. Pr	eston, M	aryland :	21655
80= 5		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 (Removal from State	20b. Place of D cemetery,	crematory (or other place)	-		c. Location - City o	r Town, State
Department mportant: any injury		'4 □Donation 5 □Other (Special		Maryla Shore	Veter	ans' Cem.	10/5/		eulah, Ma	aryland
Deparimon in poor in p		21. Sign up a of Funeral Service Lice	D Maca		Moor Moor	and Address of F E Funeral	Home,	P.A.		
		23a. Part1. Enter the disease, or con	polication, that caused th	e death. Do not	12 S	outh Seco	ond Str	eet, Den	ton, Mary	rland 21629 Approximate
		shock, or heart failure. List only Immediate Cause (Final	one coure on each line.	- 100	~ ~ ~		T.			Interval Between Open and Death
Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a c	consequence of	CH	SDIML	411	ARCTI	O/V	DOUTE
Examiner		Commendation line and alleling	HYDERTE	NOWF (ARI	VOVA-COS	WAR	DISE	ACE	chmnic
2 %	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):			11	0100		Carrier Crisics
ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c							
ing raw requires that the beain centilicate be execution has been signed by the attending physician and bage 2 should be detached for use as the burial-trains.	cal E		Due to (or as a c	onsequence or).						
phys s the			d							
attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of de	Nivery
d for	iciai	in the past 12 months?	1□Live birth 2 (4□Pregnant at tirr		3 □Ectopio 5 □ Other	pregnancy (specify)			Month Month	Day Year
by the	hys	9 Unknown	9□ Unknown							
been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death but r	not resulting in th	e underlyin	g cause given in Pa	art I.	23e. Did tobac	co use contribute t	o the cause of death?
is ue	ted					·		1 🗌 Yes	2 □ No 3 □ P	robably 4 Jnknown
as be	Completed							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
age	Con							performed	d? death?	s 2 No
(0 00	Be	25. Was case referred to medical examiner?					ace of Death	(Check only one)		
(0 00	ш	1∰ Yes 2 No		2 ER/Outpa					e 6 Other (Spe	ecify)
(0 00	۵.		OD- Date of Inform	28b. Tim		28c. Injury at Work?		3d. Describe how	injury occurred	
rnyelcien: rthis certifica ral director, p	۵.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	<i>ear)</i> Inju						
ding Physician: After this certifications of the control of the c	۵.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	n St. St.		М	1 □ Yes 2		If Leasting /Street	t and Number of C	10
aing Physician: After this certifications of the color, is	۵.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28e. Place of Injury building, etc. (- At home, farm, Specify)	М			If. Location (Stree City or Town, S	et and Number of R	ural, Royle Number, 🦙
aing Physician: After this certifications of the color, is	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Pl	28e. Place of Injury building, etc. (- At home, farm, Specify)	street, fact	ory, office	28	AESTON	MO 3/6	55
ang rnyeicien: n. After this certifica funeral director, p	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Pl	28e. Place of Injury building, etc. (- At home, farm, Specify) Ny knowledge, diamination and/o	street, fact	ory, office	28	AESTON	MO 3/6	55
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ang Pnyelcien: h. After this certifica funeral director, p	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one).	28e. Place of Injury building, etc. (CONFIED ysician: To the best of miner: On the basis of ex	- At home, farm, Specify) Ny knowledge, diamination and/o	street, fact	ory, office d at the time, date on, in my opinion,	and place, and death occurred	City or Town, S ALSTON and due to the caus d at the time, date	e(s) and manner a and place, and du	s stated.
ang rayerten: n. After this certifications of the color, is	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one).	28e. Place of Injury building, etc. (CORNELS) To the best of manner: On the basis of exand manner stated ACMACUA CORNELS To the basis of exand manner stated CORNELS To the basis of exand manner stated CORNELS To the basis of exand manner stated CORNELS To the basis of exand manner stated CORNELS TO THE	- At home, farm, Specify) D NR R ny knowledge, do amination and/o	M street, fact PD ath occurre investigation, Print)	ony, office ad at the time, date on, in my opinion, of get. License numb	and place, and death occurred	City of Town, S AESTON Ind due to the caus d at the time, date	e(s) and manner a and place, and du	s stated.

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ORIGINAL

			For State Registrar	State of I	Maryland		artment of H <i>tificate of L</i>		d Mental Hy	giene Reg. No.		32800
ľ	Dhamisi		1. Decedent's Name (First, Middle, L	ast)					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Marianne Green						Septem	ber 2		
	Examin	er	4a. Facility Name (If not institution, g		er)		4b. City, Town, or	Location of [Death		County of Death	
_			10712 Great Arb 5. Social Security Number 6.		Age (In yrs. I	ast hirthday	Potomac If Under 1 Year	If Under 24	Hrs. 8 Date of Bir		ontgome	
	Funeral Director		335-28-4252	1 □ M 2 1 F	72		Months Days		Hrs. 8. Date of Bin (Month, Da 12/20/	ÿ, Year) 1931	I 1 1 1	place (State or Foreign ntry) Lnois
		t	Usual Residence of Decedent									
	rylan Thow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-fa	Directo	MD Montgom	ery	Pot	omac						
	vith the	Dire	10e. Street and Number	n .			10f. Zip Code			-	en of What Cou	ntry?
	s 23e	ara	10712 Great Arb	12. Was Decede	nt Ever in III	S 13	20854	ispanic Origin	? (Specify Yes or No	U.S.	• A • 4. Race - Ameri	can Indian.
35	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, Ital Medical Exactiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Force	ss? ∑No		if Yes, specify Cuba 1 ☐ Yes 2)X No	Specify:	Puerto Rican, etc.)		Black, White, Specify: White	etc.
3-003p	thou atura	ed	15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b. Kin	d of Business/Ir	ndustry
<u> </u>	Z nic 72	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4)	or 5+)		kind of work done of DO NOT use retired			DI-	- to 1	
7	d with giene er tha	E O	Elamanary, dosainaary (d. 12)	5+	,	Fine	Arts Pho				otograph	1y
	be file tal Hy d oth	Be (17. Father's Name (First, Middle, La	st)					Name (First, Middle,		Sumame)	
Maryian	should be nd Mental marked o umatic eve	ဥ	Max Green						Bregstone		T	- 0-4-1
a	12 sh and n 7 is m		19a. Informant's Name/Relationship Philip Bregston				•		or Rural Route Numbe			
	Health Health Frank Grant		Philip Bregston 20a. Method of Disposition	, 5011	20b. P		sition (Name of matory or other place		rive, Poto		Mary La. cation - City or T	
و	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		וטוג			,	0/03/2004	Bros	ntriond	Maryland
		1	21. Signature of Funeral Service Lic		Л		2. Name and Addres	-	Simple Tr			Haryrand
ñ	permit. Departr Importa any inj once.		Jew Som L	heck- Tha	elli/	1	.040 Rocks	ville I	Pike, Rock	ville	e, Maryl	Land 20852
	Pnysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final		sed the death h line. tatic	n. Do not en	er the mode of dyin					Approximate Interval Between Onset and Death 7 months
	/Medical Examiner		disease or condition resulting in death)	a	as a consequ		direct					, moneno
	LAdillile	-ia	Sequentially list conditions, if any, leading to immediate	b Due to (or	as a consequ	uence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C								
o	cate be executed thy sician and the burial-transit		resulting in death) Last		as a consequ	uence of):						
8760	ate be nysici he bu	dical		d								
30	e as t	Med	IF FEMALE:	00 - 16								415
Вох	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?		me orpregna h 2. ∐Fetal itat time of de	Ideath 3[□Ectopic pregnancy □ Other (specify)	,		2:	3d. Date of deliv Month	ery Day Year
P.O.	the de	ysic	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unknow		eatii 30	_ Other (specify)			- 11		
<u>. </u>	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by Pr	Part II. Other significant condition:	s contributing to deat	th but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	se contribute to t	the cause of death?
rds	w requires been sig should be								11	Yes 2□	No 3□Pro	bably 4 X Unknown
၀	aw re	Completed							24a. Was		24b. Were auto	opsy findings available ompletion of cause of
ř	The law ate has page 2 s	mo.							perfo 1 ☐ Yes	rmed? 2X No	death? 1 ☐ Yes	
Ita	i ician : Th certificate rector, pag	Be	25. Was case referred to medical examiner?						Death (Check only o	ne)		
5	Physician: r this certifica ral director, I	2	1 ☐ Yes 2 X No		atient 2			4 LINUIS	ing Home 5 💢 Resi			fy)
חכ	ding F	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	28b. Time o Injury	Wor	yai k? Yes 2∐No	28d. Describe	iow injury	Occurred	
Division of Vital Records,	l or Attending after death. Director: After in by the fune	ficat	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of	ftnjury - At ho	ome, farm, st	reet, factory, office		28f. Location (Street and	Number or Run	al Route Number,
2	al or after after I Dire	Certification:	4 Homicide	building	, etc. (Specifi	y)			City or To	vn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the basi aminer: On the basi and manne	is of examina	wledge, deat tion and/or in	h occurred at the tir	ne, date and ppinion, death	place, and due to the occurred at the time,	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier	1/	1	- Λ	29c. Licens	e number			signed (Month,	
	10		+ Joseph "	7.11099	erly	MD	D3240	7		Sept	ember 2	9, 2004
	1-		30. Name and address of person w									
			Joseph Haggerty,				Dr, Rocl	kville,	, Maryland	2085	50	
	Sta Regist	ate rar	31. Date filed (Morith, Day, Year) OCT 01 2	2004	jistrar's Signa	J.	Sports	1				

			For State Registrar	State	of Maryla	•	artment of F		and Men		ene g. No. 11	22011
			Decedent's Name (First, Middle	e, Last)						Date of Death		3. Time of Death
	Physicia /Medic		Katie	De	an				Se	ptembe	r ^D 25, 2004	7:45 PMM
	Examin		4a. Facility Name (If not institution	n, give street and r	number)		4b. City, Town, o	r Location of	of Death		4c. County of Death	
			Springbrook Nu				Silver				Montgome	
	Funeral		5. Social Security Number 247-40-6780	6. Sex 1 M 2 1 F		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. [Date of Birth Month, Day, pr 30,	Year) 9. Birth Cou	place (State or Foreign
	Director		Usual Residence of Decedent		01				А	pr 50,	1923 3000	h Carolina
	yland		10a. State 10b. County		10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Mar e-f st	ctor	Maryland Prince	George'	s Up	per Mar	lboro					1X Yes 2 □ No
	or 28	Directo	10e. Street and Number				10f. Zip Code			10	g. Citizen of What Cou	intry?
	ath w 1236	rai	100 Chartsey S				20774				United Sta	
	er de Items	Funerai	11. Marital Status	Armed	Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican	gin? (Specify , Puerto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White	
36	I', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	if Yes, 0	s 2∭No Give Dates:		1☐ Yes 2K No	Specify:			Specify: B	lack
ğ	2 hou			nt's Education	٠	16a. Dece	dent's Usual Occup	ation		1	6b. Kind of Business/I	ndustry
215	en "n	Completed	(Specify only higher Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	kind of work done DO NOT use retired	1)	or working	1	Walter Reed	1 Army
5	ygien ygien t. Ihe	Con	11			Adn	inistrat:			1	Medical Ce	nter
Maryland 21215-0036	be fill tal H d oth	Be	17. Father's Name (First, Middle,	Last)							laiden Sumame)	
<u>S</u>	d Mer narke	ဥ	W.H. Gilliard 19a. Informant's Name/Relations	hin (Tuna Brint)		10h Maili	na Address (Street		a Lee (City or Town, State, Zi	in Code)
<u>a</u>	d 2 sl th an t7 is r treur		Angelita Edwar		ddaughte		_					20774
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show empty injury or other treumatic event, the Madical Examinar must be multified at once.		20a. Method of Disposition	ub (Brain		Place of Dispo	sition (Name of	-	Date		Oc. Location - City or T	own, State
Baltimore,	Se se se se se se se se se se se se se se		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				matory`or other placed U.M.C.	1	0/2/04		Anderson, S	SC.
≣	partm porter inju		21. Signature of Funeral Service		,			ss of Facility	McGuir	e Fune	eral Servic	
m	E E E E		lendre I	loupse	/	7	400 Georg	ja Av	e. N.W	l., Was	shington, I	o.C. 20012
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that t only one cause or	t caused the de							Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	, I	nanitio	n						Onset and Death
	/Medical Examiner		resulting in death)	Wi	to (or as a conse						1.4	
	LAdililiei	<u>_</u>	Sequentially list conditions,		evere Co		Spinal S	tenos	is			
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	_	egenerat		thritic					
	al-trai	Examiner	that initiated events resulting in death) Last		to (or as a conse		LHITLLIS					
8760,	cate be executed physician and the burial-transit	dicail		d								
9	tificate ng phys as the	fedi	IE EEN IN C	-7.00								
Вох	leath certific attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		Ectopic pregnancy	,			23d. Date of deliv	•
	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of		Other (specify)				Month	Day Year
P.0	that the de led by the a detached	Phy	Part II. Dther significant conditi	ons contribution to	death but not re	esulting in the u	nderlying cause giv	on in Part I		23e Did toba	acco use contribute to	the cause of death?
ds,	ires tha signed d be dei	d by	Chronic renal				dementia			1 ☐ Yes		bably 4 Unknown
Sor	w requir been si should I	ete		1011010	,	LINE D				24a. Was an	24h Were aut	opsy findings available
Rec	The lav	Completed								autopsy perform	prior to co	ompletion of cause of
Vital Records,		e Cc	25. Was case referred to medica	1				26 Place	-	1 ☐ Yes 2 I		2LJ No
<u> </u>	ysicien: nis certifica director, p	o B	examiner? 1 □ Yes 2 🏋 No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth				nce 6 Other (Speci	fy)
υot	a = ₽	T :uc	27. Manner of Death 1 XNatural 5 Pendin	/ 1.4.	te of Injury onth, Day Year)	28b. Time o	f 28c. Injur Wor				w injury occurred	
Sio	endir eath. or: Al	catic	2 Accident investi	igation			M 1	Yes 2□N				
Division	l or Atten after deat Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 28e. Pla	ice of Injury - At ilding, etc. <i>(Spe</i>	home, farm, st cify)	reet, factory, office			Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	pitel ours a erel [29a. Certifier 1 X Certifyii	na Physician: To	the best of my k	nowledge deat	h cocurred at the tir	no date and	d place, and	due to the car	use(s) and manner as	Ptatod
	e Hospitel 24 hours a e Funerel letely filled	edical		Exeminer: On the							te and place, and due	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Me	29b. Signature and title of certifie				29c. Licens	e number		29	d. Date signed (Month,	Day, Year)
)	9 /		Aum To	n Br	ndens	mo	D002	6564		S	eptember 28	3. 2004
	V		30. Name and address of person		6/	em 23a) (Type,					- r	, =00,
			Susan M. Gin				g Street,	N.W.	, Wash	ington	n, D.C. 20	010
	Sta Registi		31. Date filed (Month, Day, Year,		. Registrar's Sig	nature B	pouls					
	riegisti	- CI	SEP 30	CUU4		/						

State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death	2010
	Physician	Mourice Ellis Month Dey Year 9 -27-2004	S Am
	/Medical Examiner	4b City Town or location of Death 4c County of Death	
^^ 		M. to amory Garage Ral Horatal Oliver Martana	e (State or Edreion
	uneral Pirector	5. Social Security Jumber 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Jumber 9. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. Month, Day, Year) 9. Birthplact Country, Months Days Hours Min. Month, Day, Year) 9. Birthplact Country, Months Days Hours Min. Months Days Hours M	
Mend	A H		Inside City Limits
Man	in-rah fred ctor	Maryland Montgomery Silver Spring	1XYes 2□No
death with the Marylend	r tems 23s or 28s-f show niver must be notified at Funeral Director	10e. Street end Number 10g. Citizen of What Country	, .1
eath v	ns 234	3701 International Dr. #321 20906 6503 United Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - American Black, White, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.)	
Į.			t.
5-0020 72 hours after	- 5	3 Widowed 4 Divorced Year or Detes: //_ 3 - 445	
215 -	tal hygiene. I other then "nature svent, the Medical I Be Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indus (Give kind of work done during most of working life. DO NOT use retired)	ıry
212 dwith	omp	Elementary/Secondary (0-12) College (1-40r 5+) Department Chief Federal G	overnment
	In and Mental ryglene. 7 is marked other than traumatic event, the Ma	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	merked meric ev	Eugene Ellis 19a. Informació Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town). State, Zip Co	ode)
Ma nd 2 s	27 is r 27 is r r trau	1 10 5 FUR 16	
ore,	r othe	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Date 20c. Location - City or Town cemetery, crematory or other place)	, State
Baltimore	ment: If ant: If ury o	4 Donation 5 Other (Specify) Gate of Heaven 10-5-04 21 Iver Spr	ing, Mb.
Ball	mport my Inj	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Signature of Fune Rall 24. Signature of Funeral Service Licensee 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 21. Signature of Funeral Service Licensee	tomes
		20904	ال
Phy	ysician	23a. Partf. Enter the disease er complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	oproxi <i>m</i> ate terval Between nset and Death
/N	Medical	disease or condition	2004
Lx	amintor.	resulting in death) Due to (or as a consequence of):	-004
petr	in and iel-transit	b. Kypertarion	
0, exec			904
68760 tificeta be	the the	that initiated events resulting in death) Last Due to (or as a consequence of):	22 6
=	O 60	E COLO TO LINE THE	204
. Box	d for usa	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the	e cause of death?
ords, P.O.	signed by the ettendin d be datached for usa d by Physician/N	1 □ Yes 2 No 3 □ Probab	oly 4 Unknown
	signer ald be d	24a. Was an autopsy 24b. Were	autopsy findings
CO W raq	cata has been si page 2 should be Completed	performed? availar comp of dec	letion of cause
I Rec	page 2 s	1 Yes 2X No 1 DY	es 2X1No
of Vita	Be sctor	25. Was case referred to medical examiner?	
Phys of	is is	1 Inpatient 2 A Envoying from 5 Inesidence 6 Dotter (Specify)	
Sion	eath. or: After thi tha funeral cation: T	1 Montanter 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 □ Yes 2 □ No	
Division of Vital Records, or Attending Physician: The law requires the	arter des Directo J in by th	3 Suicide 4 Homicide 4 Could not be determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rur	oute Number,
Di Hospital or	within 24 hours after death. To the Funeral Director: After the complately filled in by the funeral Medical Certification:	29a. Certifier 1x Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as state	ed.
Hos	Fun 24 h	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.	e cause(s)
To th	To the	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date)	y, Year)
	Du	D17729 9/29/08	
CR	-(1)/Va	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOODE B. Pitnich IND 9271 (vietrite Pa Silve Spring; MS)	ogio
	State	31. Date filed (Month, Day, Year) 32 Registrer's Signeture	
	Registrar		

			For State Registrar	State of M	laryland / De	partment of ertificate of			Reg/No. 1 4	32813		
	Physici	an	1. Decedent's Name (First, Middle, Last Elizabeth		fana			2. Date of Dea	Day Year	3. Time of Death		
	/Medic	al	4a. Facility Name (If not institution, give		fana	4h City Town	or Location of De		23, 2004 4c. County of Death	5:34a M		
	Examin	er	Montgomery Ge			Oln		i di i	Montgon	nerv		
	Funeral		Social Security Number 6. S		ge (In yrs. last birthd	ay) If Under 1 Year Months Days		rs. 8. Date of Birt in. (Month, Da		place (State or Foreign ntry)		
	Director		none	□M 2 只 F	68 Yrs	. Internal Days	110013	4/11/1	936 Sie	36 Sierra Leone		
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits		
	Mary Ff sh	tor	Md Montgo	mery	Silv	er Spri	ng			1 ☐ Yes 2X☐ No		
	3a or 28e	Funeral Director	10e. Street and Number 14227 Grand P:	re Road	#203	10f. Zip Code 209	06		10g. Citizen of What Cou Sierra Lec			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itams 23a or 28e-f show apportant: If Item 27 is marked other than "natural; or Itams 23a or 28e-f show any loury or other traumatic event, Ite Medical Examiner must be multiped at ances.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	3. Was Decedent of If Yes, specify Cul		(Specify Yes or No- erto Rican, etc.)				
21215-0036	hin 72 hou a. "natura Medical E	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	16a. De	cedent's Usual Occu ive kind of work done e. DO NOT use retin	upation e during most of v ed)	working	16b. Kind of Business/In	dustry		
7	ed wit ygiene yer tha	Соп	12			Homemake			Own Home	<u> </u>		
Maryland	ntal H ed oth	To Be	17. Father's Name (First, Middle, Last) Sorie Turay)			18. Mother's N	lame (First, Middle, I Turay	Maiden Sumame)			
3	should nd Mei mark matic	P	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Stree		_	er, City or Town, State, Zip	Codeh o o o c		
E	alth ar 27 is rr trau		Victoria Free		hter 14	227 Grai	nd Pre	Road #2	03 Silver	Spring, Md		
altimore,	Pages 1 and of Heren of It is it its or other		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 1 ★ □ Donation 5 □ Other (Specific		cemetery,	sposition (Name of crematory or other place) Rd.Cem		Date 20/04	20c. Location - City or To Lumley Fr Sierra Lo	eetown,		
Balti	permit. Departn Imports any inju		21. Signatur A Funeral Service Lics	me .		Philip I	ess of Facility D. Rinal	di Fune	ral Servic lver Sprin	e,P.A.		
	Pnysician /Medical		23a. Part 1. Enter the lisease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Athero.	ed the death. Do not line. General (September 1) S a consequence of):	enter the mode of dy	ing, such as card	iac or respiratory ar	rest, Sedse	h proximate Interval Between Onset and Death		
8760,	Examination and buriar-transit site buriar-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequence of):							
P.O. Box 6	death certif e attending ad for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of delive Month	ery Day Year		
	quires that the n signed by th uld be detache	by	Part II. Other significant conditions of	contributing to death	but not resulting in th	e underlying cause g	iven in Part I.	23e. Did to	obacco use contribute to to	he cause of death?		
Vital Records,	The law requires ate has been sign page 2 should be	Completed						24a. Was autop perfor 1 \sum Yes	sy prior to co	psy findings available mpletion of cause of		
Vita	tending Physician: Theath. tor: After this certificate the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	V	0	thor	eath (Check only or				
of	Phys r this ral di	. To	1 Syes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj	ury 28b. Tim	IIBIIL 3 DOX	4 🗀 Nursing		lence 6 Other (Specificow injury occurred	(y)		
ion	Attending F r death. ector: After by the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year) Inju	y Wo	ork?]Yes 2∏No					
Division	ai or Attendi s after death. ii Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined	289. Place of it	njury - At home, farm tc. (Specify)	street, factory, office)	28f. Location (S City or Tow	treet and Number or Rura n, State)	al Route Number,		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the bes miner: On the basis and manner s	of examination and/o	eath occurred at the r r investigation, in my	time, date and pla opinion, death oc	ce, and due to the courred at the time, o	cause(s) and manner as s date and place, and due to	tated. o the cause(s)		
)	To the Parithin 24 To the Foundation	Me	29b. Signature and title of certifier	Tomsko	nay, m		se number)5/9/6		29d. Date signed (Month, September			
000	_		30 Name and address of person who	Nay, 1111	7 Rockvi	le Pike	G-100	, Rock	September Ville, MD	20892		
	Sta Registi		31. Date filed (Month, Day, Year) SEP 3 0 20		trar's Signature	Spark						

		1 - State of Many		irtment of Health and M tificate of Death	ental Hygier	200i. 1	12811
		Decedent's Name (First, Middle, Last)			2. Date of Death	NO.	3. Time of Death
Physi		David Wilber	Falter		Sept. 29	Day 2004	9:20A. M
/Med Exam	dical niner	4a Eacility Name (If not institution, give street and number) 22 Ridge Road, #130	rareer	4b. City, Town, or Location of Death Greenbelt		4c. County of Death Prince Ge	
Funera Directo		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day, Ya Dec. 30, 13	9. Birthp Count New	ace (State or Foreign to) York
p. >		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc				Od Jacida Oballiania
shor shor	7		Greenbelt	Zation		'	0d. Inside City Limits
the M	ecto	10e. Street and Number		10f. Zip Code	100	Citizen of What Coun	
ath with 238 or	Funeral Director	22 Ridge Road, #130		20770	Ţ	Jnited Sta	tes
DESIGNATION CONTROL STATES TO SENTING TO SENTING THE MATCH DESIGNATION TO THE MATCH DEPARTMENT OF HEALTH AND MENTAL HYGIENE. Important: If I tem 27 is marked other then "neturel", or items 23e or 28a-f show any injury of other treumatic event. It a Madical Examinat must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: W	If	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
2 hours ature!; esture!	ted	15. Decedent's Education	16a. Deced	ent's Usual Occupation	16b	. Kind of Business/Inc	
within 72 liene. r then "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. D	kind of work done during most of worki DO NOT use retired) 1 Carrier	-	ederal Gove	ernment
IZITIO A lid be filed fental Hyg rked other tic evant,	To Be C	17. Father's Name (First, Middle, Last) Wilber	Falter	18. Mother's Name Rosa	(First, Middle, Maio		ards
INICAL Y Ind 2 shoul Ith and M Ith and M 27 is mark treumati	-	19a. Informant's Name/Relationship (Type, Print) Lossie M. Falter -wife		g Address (Street and Number or Rura			
S 1 ar f Hea item 2	Ь		20b. Place of Dispos	sition (Name of Datory or other place)	ate 20c.	Location - City or To	wn, State
E age E	0	1 N Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)		tional Mem. Park 10/2	2/2004 La	aurel. Mar	vland
permit. Pages Department of Important: If it	once.	21. Signature of Funeral Service Licentee		nald V. Borgwardt 00 Powder Mill Roa			
4 7 4	2	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.					Approximate Interval Between
Physicia	n	1	te Cancer				Onset and Death
/Medica	al	resulting in death) Due to (or as a c	onsequence of):				
Examine		Sequentially list conditions, b.					
ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):				
cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a c	onsequence of):				
ofou, sate be ex thysicien the burial	dical E						
	edic	d					
death certifi e attending	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2		Ectopic pregnancy		23d. Date of delive	ry
e deat the attr	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Other (specify)		Month	Day Year
hat th od by i		Part II. Other significant conditions contributing to death but n	not resulting in the un	derlying cause given in Part I	23e Did tobacc	o use contribute to th	e cause of death?
The law requires that the death certiful to the law requires that the death certiful to the been signed by the attending bage 2 should be detached for use as	ed by	Aspiration Pneumonia; Hyp	-				ably 4 Unknown
aw re	Completed	Macular Degeneration			24a. Was an autopsy	24b. Were autop	osy findings available of
The law cate has by page 2 s	e e				performed 1 ☐ Yes 2 ☐X	? death?	
VICAL F sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
Physic this co	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient)
ling F	lon:	27. Manner of Death 1 □ Matural 5 □ Pending 28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Work?	28d. Describe how in	njury occurred	
VISION Attending ar death. ector: Afte	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury	- At home, farm, stre		28f Location (Street	and Number or Rura	Route Number
ior A efter Direction by	Certification;	4 Homicide determined building, etc. (Specify)	set, factory, office	City or Town, St.		rioute rutilber,
To the Hospitel or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of n (Check only one) Certifying Physician: To the best of n (Check only one)	amination and/or inv	occurred at the time, date and place, a estigation, in my opinion, death occurred.	and due to the cause ed at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
Fo the within Fo the	Me	29b. Signature and title of certifier		29c. License number D55559		Date signed (Month, L	
1				טטטטט	Sep	otember30,	2004
5		30. Name and address of person who completed cause of deat Thomas E. Maslen, M.D. 75.	h (Item 23a) (Type, F 25 Greenw a	Print) ay Center Drive, #	!316 Green	belt, MD 2	20770
Regi	State strar	31. Date filed (Month, Day, Year) SEP 30 2004 32. Registrar's	Signature	Sparks		•	

ase i	be of Little in place indentit	illin.	LIISUIC AII	Cobies Ale L
	State of Maryland / Departmen	t of H	ealth and M	ental Hygiene
	Certificat	e of l	Death	Reg. No.

lE.	LLE FOG	AR.	I'Y	State of M	arvland	/ Depa	artment of H	lealth and M	ental Hva	iene			
		•	1 - State Registrar		, , , , , , , , , , , , , , , , , , , ,		rtificate of I			eg. No.		20215	
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat Month		V	3. Time of Death	
	Physicia /Medic		ROSHEL	LE FOGARTY					SEPTEME	BER 28,	Year 2004	7:05 P ^M	
	Examin		4a. Facility Name (If not institution		r)		4b. City, Town, or	r Location of Death		4c. County			
			7210 RED TOP F	ROAD			HYA'	TTSVILLE		PRINC	E GEX	ORGES CO	
	Funeral		5. Social Security Number		ige (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign	
	Director	1	219-53-2457	1□M 2 X F	23	Yrs.			Jan. 28			aica	
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Fown or Le	ocation					10d. Inside City Limits	
	aryla shov	_	Toa. State		Too. Only,	OWN OF EC	odion				1	XXYes 2 □ No	
	he M 8a-f	Director	Md. P.G.		Tako	oma P				0			
	vith ti	吉	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cour	ntry?	
	s 23e	a	6815 Redtop Rd			10	2091		-7 M N -	Jamaic			
	er de Item	nu	11. Marital Status	12. Was Deceden	?	13.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	can Indian, etc.	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	1 Never Married 2 Marri 3 Widowed 4 Divorced	If YAS Lilva**	3140		1 ☐ Yes 2 No	Specify:		Specif	^{fy:} B1a	ck	
ð	2 hou atura cal E	pel	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/In	dustry	
7	7, nin 7; In "ni Medi	Completed		st grade completed) College (1-4o	r 5+\			during most of work d)	I				
2	d witi	E	Elementary/Secondary (0-12)	20/10/30 (1 40/		Cent	ral Proce	ssing Te	ch.	Private			
פ	e file othe vent,	Bec	17. Father's Name (First, Middle, Last) Central Processing Tech. Private 18. Mother's Name (First, Middle, Maiden Sumame)										
<u>a</u>	dental dental rked c	ToE	Roy Fogerty					Euphager	ne Parch	ment			
ary	should and Men s marke umatic	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rout								, State, Zip	Code)	
	and 2 ealth a n 27 is		Euphagene Fogerty			733 N	ew Hampsh	nire Ave.	#814 Ta	koma Pl	k. Md	. 20912	
altimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition	0 77	20b. Plac	e of Dispo	osition (Name of matory or other place	20c. Location	- City or To	own, State			
Ĕ	Page nent int: If		1 🖺 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (S				Cem. 10			Montego	o Bav	. Ja.	
<u>=</u>	mit. partm porta oorta / Inju		21 Signature of Funeral Se	Licensee	<u> </u>		2. Name and Addres		ohnson &				
m	9 5 5 6	6	Lon	/_		7	16 Kenned	ly St. N.V	W. Wash.	D.C. 2	20011		
	100		23a. Part1. Enter the disease, or shock, or leart failure. List	complications that cause	ed the death.	Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory arre	est,		Approximate Interval Between	
	Physician :		Immediate Cause (Final			01	.) 4.	111	OV.	11.1		Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or a	is a consequer	nce of):	219	ul (i).	stat The		_		
	Examiner						,						
	يجمعي	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Linderlying	Due to (or a	is a consequei	nce of):							
	cutec nd ransi	Examlner	Cause (Disease or injury that initiated events	c									
o`	an ar rial-t		resulting in death) Last	Due to (or a	is a consequer	nce of):							
376	ss that the death certificate be executed gned by the attending physician and be detached for use as the buriat-transit	Physician/Medical		d									
39	ntifica ng ph	Med	IF FEMALE:										
õ	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	ne of pregnanc 2 Fetal de		□Ectopic pregnancy	/		1	ate of delive onth	ery Day Year	
P.O. Box 68760,	e des the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Inknown	4□Pregnant 9□Unknown	at time of deal	th 5[Other (specify)			IVI		, I Dai	
<u>Р</u>	that the de led by the a detached t	Phy				ne in the :		i- Dod I	220 Did to		tributa to t	he cause of death?	
Ś	es tha gned be de	by	Part II. Other significant conditi	ons contributing to death	DULTION TESUR	ng in me t	indenying cause giv	on at Fatti.	236. Diu tot	COU	minute to the	le cause of death?	

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

1 Yes 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 1 XYes 2 ☐ No 27. Manner of Death 1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Pending investigation Found 912864

28b. Time of Injury Fund 18 48M

Other: 4 Nursing Home 5 Residence 6 2 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

Be Completed

Certification:

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) undence

Trouble 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number OCME

29d. Date signed (Month, Day, Year) SEPTEMBER 29, 2004

30. Name and address of person who completed care of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

within 24 hours after death, To the Funeral Director: After thi completely filled in by the funeral of

Division of Vital Record

THESDOREM.KIN 31. Date filed (Month, Day, Year) OCT 0 4 2004



		State of Manyland / Don		•
		101	eartment of Health and Me ertificate of Death	2001 2001
		Registrar 1. Decedent's Name (First, Middle, Last)		Reg. No. 3. Time of Death
Physici				Month Day Year
/Medi Examir			4b. City, Town, or Location of Death	eptember 28 2004 0535 M 4c. County of Death
CAdiiii	ier	DORCHESTER GENERAL	CAMBRIDGE	DORCHESTER
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director		214–07–7911 ¹ ♥ ¹ ♥ 94 Yrs.	Months Days Hours Min.	March 6, 1910 Maryland
pu a		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
sho	5		Cambridge	1 X Yes 2 ∏ No
	ect	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Ind 21215-0036 /// be filed within 72 hours after death with the Maryland hat Hygiene. Id other then "natural", or Itams 23a or 28a-1 show event, if a Medical Ever in writnest be rediffed at	Funeral Director	108 Somerset Ave.	21613	U.S.A.
death C	lera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	
or Ita	교	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No		-2-11
ours a	Completed by	3 Widowed 4 Divorced Year or Dates: WWII	1 ☐ Yes 2 🕱 No Specify:	specify: White
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hyglene. If Is marked other then "natural", or traumatic event, ir Medical Ever.	etec	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
	m	Elementary/Secondary (0-12) College (1-4or 5+)	accountant	auto dealer
C 2	ပိ	17. Father's Name (First, Middle, Last)		First, Middle, Maiden Sumame)
and the formal had be formal had be and old be seval	Be			n Meekins
Aarylan 2 should be 2 should be 1 and Mental 1 s markad (a	ပို	-		Oute Number, City or Town, State, Zip Code)
			Somerset Ave., Cambr	
is 1 and 3 Health itam 27 other tr		20a. Method of Disposition 20b. Place of Disp	the second secon	
Baltimore, permit. Pages 1 ar Department of Heal Important: If item; any injury or other once.		1 Abbutal 2 Cremation 3 Hemoval from State		/1/04 Cambridge, MD
mit. I martin south		21. Signature Funeral Service Licensee 2	22. Name and Address of Facility Thon	mas Funeral Home P.A.
m Farea			700 Locust St., Camb	
		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arrest, Approximate Interval Between
Physician		Immediate Cause (Final disease or condition GASTRIC VOLV	ULUS	Onset and Death
/Medical		resulting in death) Due to (or as a consequence of):		2 T 11000
Examiner		Sequentially list conditions, b.		
sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or might)		
recut and I-tran	хап	that initiated events resulting in death) Last C		
760, te be executed ysician and e burial-transit	caiE			
687 ifficate g phys as the	gic	d		
¥ pe de s	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
death death of atten	icia	in the past 12 months? 1 Yes 2 No 1 Yes 2 No	□Ectopic pregnancy □ Other (specify)	Month Day Year
rat the ded by the detached	hys	9 ☐ Unknown		
- 2 9 9	β	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
VI(al HECOrdS, sician: The law requires t certificate has been signe rector, page 2 should be o				1 Yes 2 No 3 Probably 4 Unknown
ecc lawr as be	pie			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
HREC The law cate has b	Completed			performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
Of VITAL Physician: The this certificate ral director, pag	Be	25. Was case referred to medical	26. Place of Death C	theck onlone
Of Physical this call directions and directions and directions and directions are directions and directions are	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		5 Residence 6 Other (Specify)
DIVISION OF to Attanding Phy after death. Diractor: After this Lin by the funeral d	ion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year) 1 Pending (Month, Day Year)	of 28c. Injury at 28d Work? M 1 ☐ Yes 2 ☐ No	. Describe how injury occurred
USI deatl deatl ctor: y the	lical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		Location (Street and Number or Rural Route Number,
affer DIV	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State)
UNISION Of VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear	th occurred at the time, date and place, and	due to the cause(s) and manner as stated.
To tha Hos within 24 h To tha Fur completely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s)
To tha within 2 To tha complet	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		William / Can	D43238	SEPTEMBER 28, 2004
		30. Name and address of person who completed cause of death (Item 23a) (Type,		
		WILLIAM BAIR 100 BRAMBLE	ST. CAMBRIDG	E MD 21613
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	M =	
* negisti	al	SEP 3 0 2004		

Daniel Foxwell

04-6099 B.K.S				Type or Pri							•			
MARGERY 1	H. F	RI.	For State Registrar	State of M	aryland /	•	tment of F ificate of		Mental Hy	/giene Reg. No	1001	32817		
D	husisis	-2,4	1. Decedent's Name (First, Middle, Las	st)					2. Date of D Month	eath Da	y Year	3. Time of Death		
	hysicia /Medica xamine	al.	Margery Holla: 4a. Facility Name (If not institution, give UNIVERSITY HOSP	street and number)				or Location of Dea MORE CIT	SEPT	. 2		12:09P ^N		
	neral ector		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. last b	irthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Year)		hplace (State or Foreig		
70			578-01-1196 Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation		July	20,	1912 N	Iaryland 10d. Inside City Limits		
death with the Maryland	CAlified 3	Funeral Director	MD Queen 10e. Street and Number	Anne	Queen	sto	VN 10f. Zip Code			10= 0	1 ☐ Yes 2 ☐ No			
with	38 0	Di	7133 First Av	enue			2165	58		rog. Oil	USA	and y :		
death	arruna arruna	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. W		lispanic Origin? (S an, Mexican, Puei	Specify Yes or N	0-	14. Race - Ame Black, Whit			
ire, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Marylan of Mental Hyglene.	ENDITOTING	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2□ If Yes, GiveX X Year or Dates:			Yes 2√ No	Specify:	110 1 110 27 17 17 17 17 17 17 17 17 17 17 17 17 17	Specify: White				
15-(Uatr	Completed	15. Decedent's Ed (Specify only highest gra		168	a. Decede (Give k	nt's Usual Occup ind of work done	pation during most of wo d)	orking	16b. K	ind of Business	Industry		
within	Tie M	duc	Elementary/Secondary (0-12)	College (1-4or	5+)		nemaker				House			
d 2	ant, I	Be Co	17. Father's Name (First, Middle, Last)	4		пО	пешалет		ame (First, Middle					
Maryland nd 2 should be file lith and Mental Hy	tic av	ToB	William Graft	on Holla	.nd			Ella	Claget	t Ke	ngla			
ary	s ma		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Street	and Number or R	lural Route Numi	ber, City o	or Town, State, 2	Zip Code)		
and 2	er tra		Pamela Friel	Bernard/), Quee	nstown	, Ma	ryland	21658		
Baltimore, Jermit. Pages 1 a	Important: If its any injury or of once.	Ī	Pamela Friel Bernard/niec PO Box 10, Queenstown, Maryland 21658 20a. Method of Disposition State Commatter											
PT.ys	ician dical niner	ner	23a. Part1. Enter the disease, or community of the control of the	a. Complic Due to (or as	ations	Of of):	the mode of dyin	Centro	Approximate Interval Between Onset and Death					
1 0 0	a <u>−</u>	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):								_		
6876(the bi	dica		d										
O B	ed by the attending physician detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1. Yes 2 No 9 W Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal deat		ctopic pregnancy Other (specify)	у			23d. Date of delivery Month Day Yea			
ds, P	eugi pe q	ξ	Part II. Other significant conditions of	ontributing to death b	out not resulting	in the und	lerlying cause giv	ven in Part I.			u .	the cause of death?		
Division of Vital Records, or Attanding Physician: The law requires the clearh.	page 2 should	Completed							24a. Was auto perf 1 X Yes	s an opsy ormed? 2 \(\subseteq \text{No}	prior to death?	topsy findings available completion of cause of		
ian:	certificate	Be	25. Was case referred to medical examiner?					26. Place of De	ath (Check only					
of Vita	nis ca	0	1X Yes 2 No	Hospital: 1X Inpatio			JU DON		Home 5 ☐ Res	idence	6 □Other (Spec	cify)		
Vision C Attanding P	or: Atter this certific the funeral director,	edical Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		4 2	- 0		yat rk? Yes 2∭XNo		of nother	notor veh a motor	ide struck vehide		
DIVI	ed in by	Certifi	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 5 Homicide 4 Homicide 5 Homicide 4 Homicide 4 Homicide 5 Homicide 5 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 6 Homicide 7 Homicide 7 Homicide 8 Homicide								Route #	17al Route Number 50 @ Route 4		
Divisio To the Hospital or Attandi	na Funar pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Ph 2X Medical Exam	ysician: To the best niner: On the basis of manner at	of examination a	ge, death ind/or inve	occurred at the tirestigation, in my o	me, date and plac ppinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as d place, and due	stated. to the cause(s)		
To th within	no n	Me	29b. Signature and title of certifier	h.D			29c. Licens	e number C.M.E			te signed <i>(Montl</i> EPT • 22	n, Day, Year) , 2004		
35	1CK		30. Name and address of person who LING LI.		death (Item 23a)			treet, B	altimore	e, Ma	aryland	21201		

State

31. Date filed (Month, Day, Year) **SEP 2 3** 2004

3 Registrar's Signature

Registrar

			For State Registrar	State of Maryla	nd / Depa		Health and		_	32818
	Physici		Decedent's Name (First, Middle, Last, BETTY ANN GUMP)		1.1		2. Date of Death Month Septemb	Day Year	3. Time of Death 4:00 p. M
	/Medic Examin		4a. Facility Name (If not institution, give				or Location of De		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sec 235-40-4232		s. last birthday) Yrs.		ar If Under 24 H	Irs. 8. Date of Birth (Month, Day,) June 29,	(ear) 9. Bir	George's thplace (State or Foreign ountry) t Virginia
	e Maryland a-f ehow lifted at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ထ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28a-f show amy injury or other traumatic event, Ite Medical Evanties must be notified at ODGe.	Funeral Director	10e. Street and Number 6224 42nd Avenue 11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕅 No	į į	Was Decedent of If Yes, specify Co	0781 f Hispanic Origin? uban, Mexican, Pu		J. S.A. 14. Race - Am. Black, Whi	erican Indian,
Maryland 21215-0036	in 72 hours a "naturel", o leulical Ever	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grad	e completed)	16a, Dece	1 Yes 2 N dent's Usual Occ kind of work dor DO NOT use ret.		vorking 16	Specify: T	Vhite Vindustry
nd 212	e filed withi al Hygiene. I other then vent, Ine M	Be Comp	Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		ing Pers	ona1	lame (First, Middle, Ma	Private iden Sumame)	
Jaryla i	2 should be and Menta is marked raumatic e	Tol	Guy Robison 19a. Informant's Name/Relationship (Ty			•	et and Number or	a Yost Rural Route Number, C	ora se emun	second.
Baltimore, I	Pages 1 and hent of Health nt: if item 27 ry or other t		Noland Gump - Hus 20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specify)	20b. Removal from State	Place of Dispo cemetery, crea	42 Ave osition (Name of matory or other p Cemete	place)	1010001	c. Location - City or	
Balti	permit. Departming importe any inju		21. Signature of Funeral Service Licens Laudette L	ee Jasch Zari	ung 47	2. Name and Ado 739 Balt	dress of Facility	Gasch's Fur e., Hyattsv	neral Home ville, MD	P.A. 20781
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	1EM		fying, such as card	iac or respiratory arres	t,	Approximate Interval Between Onset and Death
,160,	Examiner nysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	_	equence of):	DNISM)			10.148
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩6 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	ital death 3	Ectopic pregnal			23d. Date of de Month	livery Day Year
۹.	w requires that to be signed by should be detail		Part II. Other significant conditions co	-	esulting in the u	nderlying cause	given in Part I.	5		o the cause of death?
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	the Hosp in 24 hou the Funer ipletely fill	edical	(Check only 2 Medical Exami one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	vestigation, in m	y opinion, death or	ccurred at the time, date	and place, and due	e to the cause(s)
)	Som Som	2	29b. Signature and title of certifier Number	mo			0050 95		. Date signed (Mont	
	6		30. Name and address of person who co	ompleted cause of death (It	em 23a) (Туре, Д14 W0	Print) RTHA	UE RIV	ERDALE	mp 2	0737
	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 1 200	4 32 Registrar's Sig	nature &	ale				

		•	1 - For State Registrar	State of	Marylan		artment rtificate			and M	ental Hy	giene	a o i	32819
	Physici /Medio		Decedent's Name (First, Middle, Alfreda Greenle)	•							2. Date of Dea		y Year	3. Time of Death 20:48р м
	Examin		4a. Facility Name (If not institution, Southern Md Hos				C1	into				P	County of Deat rince G	eorge's
	Funeral Director		5. Social Security Number 579-48-6880 Usual Residence of Decedent	6. Sex 1. M 2. F	7. Age (In yrs. 68	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt 10-3-3	h Year)		hplace (State or Foreign unity) Sylvania, Va
	e Maryland 3a-1 show	ctor	10a. State 10b. County Virginia FairFa	ax		ty, Town or Lo								10d. Inside City Limits 1√2 Yes 2 □ No
	th with th	Funeral Director	3100 South Mancl	nester St	#517		10f. Zip	Code 044				-	zen of What Co ted Sta	
036	be filed within 72 hours after death with the Maryland Ital Hyglene id other then "netural", or Items 23a or 28a-f show event, I're Medical Exerting must be conflict at	by	11. Marital Status 1 Never Married 2 Marrie 3 W Widowed 4 Divorced	12. Was Deceing Armed Formed In The State of	ces? 2 ∰ No		Was Decedif Yes, special		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: B1a	e, etc.
21215-0036	d within 72 ho plene. r than "natur r to Medical	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12th		4or 5+)	(Give	dent's Usua kind of won DO NOT us	k done a e retired,	turina mosi		ng		nd of Business/ mestic	Industry
Maryland ?	iould be filed I Mental Hygi harkad othar hatic evant, L	To Be C	17. Father's Name (First, Middle, L Alfred Turner	ast)					18. Mothe Margi		(First, Middle, ubbs	Maiden	Sumame)	
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If itam 27 Is marka any injury or othar traumatic once.		19a. Informant's Name/Relationsh Diane Bush / Daug 20a. Method of Disposition 1 Sebrial 2 Cremation 4 Donation 5 Other (Sp. 21. Signyt relation neral Service)	hter 3 Removal from S ecity)	1010	3100 Place of Disponenterly, cree mony M	South sition (Name and or or or or or or or or or or or or or	Man her of her place a1 P	chest ark]	er S 10-7-	St. #51	7 Fai 20c. Lo Land	cation - City or dover,	rch, Va 2204 Town, State Md rtuary Inc.
8760,	death certificate be executed e attending physician and for use as the burial-transit	Ilcal Examiner	23a Part. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (c		Hydragion (enction			Approximate Interval Between Onset and Death Death Onset and D
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ecords, P.	The law requires that the law seen signed by sage 2 should be detact	by	Part II. Other significant conditio	ns contributing to de	ath but not res	sulting in the u	nderlying ca	iuse give	en in Part I.			es 2		the cause of death?
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f Vital	Physician: T this certificat ral director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 140	Hospital:	patient 2	ER/Outpatier	nt 3 ☐ DQ/	A Othe			(Check only one 5 - Residence		Other (Spec	cify)
ion of	Attanding Ph r death. actor: After th by the funeral	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig		f Injury , Day Year)	28b. Time o Injury	M 28	3c. Injury Work 1 🗆 Y	at t? Yes 2 □		28d. Describe h	ow injury	y occurred	
Division	2 = 5	Certific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At h g, etc. <i>(Speci</i> i	ome, farm, sti fy)	eet, factory,	office		4	28f. Location (S City or Tow			ral Route Number,
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)	To with	2	29b. Signature and title of certifier	velle-			5	License	number	1			e signed (Manth Lem Bc	1, 29, 04
R	(3)		30. Name and address of person v	: Ave	7-41	121	423	30	Ring	smy	200	102	-	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 1 20	104 Keep	gistrar's Signa	ature	W							

	1	For State Registrar	State of Maryla		artment of I rtificate of			ene g. No. () () ()	32820		
Physici	an	1. Decedent's Name (First, Middle, La JOHN HENRY GRII	·				2. Date of Death SEPTEMBE	R 28 2004	3. Time of Death 3:10A		
/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death	1	4c. County of Death			
		National Institu			Bethes			MOntgomery			
Funeral Director		5. Social Security Number 6. S 432-78-6310 Usual Residence of Decedent	ex	rs. last birthday, Yrs.	Months Days		8. Date of Birth (Month, Day, 02 16	Year) 9. Birthplace (State or Foreign Country) 41 Arkansas			
show		10a. State 10b. County AR		City, Town or L Searcy	ocation				10d. Inside City Limit 11∑Yes 2 ☐ N		
the M	ecto	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Cou	ntry?		
with with	اق				72143	\		USA			
eath	era	209 Indian Trail	12. Was Decedent Ever in	n U.S. 13.		Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No-	14. Race - Ameri			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23e or 28e-f show importent: if item 27 is marked other then "netural", or items 23e or 28e-f show pray injury or other treumetic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		o Hican, etc.)	Btack, White,	ite		
72 ho	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	edent's Usual Occu	pation during most of wor ed)	rking	16b. Kind of Business/Ir	ndustry		
hen "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.							
led w tygier ther ti	S	17. Father's Name (First, Middle, Last	4 yrs.		Unkno		ne (First, Middle, M	Maiden Sumame)			
htal H ntal H ed ot	Be						Steinegge				
hould d Mer mark metic	ပ	John Henry Grif 19a. Informant's Name/Relationship		19b. Mail	ling Address (Stree			City or Town, State, Zi,	p Code)		
d 2 st th and 7 Is r treur		Johnnie M. Griff	**			rail, Sea					
1 and Heall em 2		20a. Method of Disposition			osition (Name of ematory or other pl			20c. Location - City or T	own, State		
ages nt of t: # it		1 Burial 2 Cremation 3 Control	_Hemovai from State		ematory or other piles 1 Cemete		3-04	Jonesboro,	AR.		
it. P. rtme riterial visits of the riterial v		21. Signature of Funeral Service Lice		MCDanie	22. Name and Add			Funeral Ho			
Depariment Department of the procession of the p		21. Signature of unional solution	1 00					ton, D.C. 2			
Physician /Medical Examiner		23a. Parf. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as a con	sequence of):		I and w		est,	Approximate Interval Between Onset and Death		
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a condition of the condition of th								
that the death certifics ed by the attending pl detached for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3	☐Ectopic pregnan☐ Other (specify)	cy		23d. Date of delik Month	very Day Year		
uires that signed to Id be deta	b	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause g	iven in Part I.		oacco use contribute to es 2 ፟ No 3 ☐ Pro	the cause of death? bably 4 □Unkno		
he law require e has been sig ige 2 should to	Completed						24a. Was a autops perform	ned? prior to o death?	opsy findings availa ompletion of cause o		
icien: Th certificate rector, pag		25. Was case referred to medical				26 Place of De	ath (Check only on		2010		
sicie cert irect	o Be	examiner? 1 Yes 2 No	Hospital: 1 ⊠ Inpatient	2 ER/Outpation	ent 3□ DOA	ther		ence 6 □Other (Spec	ify)		
Attending Physicien: r death, ector: After this certifics by the funeral director, p	tion; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Yea		of 28c. Inj			ow injury occurred			
Dir	Medical Certification:	3 Suicide 6 Could not 4 Homicide determine	be 200 Place of Injury		street, factory, offic	Đ	28f. Location (Si City or Town	reet and Number or Ru n, State)	ral Route Number,		
To the Hospital within 24 hours of To the Funeral completely filled	dical (29a. Certifier 1 ⊠ Certifying F (Check only one) 2 ☐ Medical Ex-	hysician: To the best of my eminer: On the basis of exar and manner stated.	knowledge, demination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occi	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)		
To the vithin To the complex c	Me	29b. Signature and title of certifier			29c. Lice	nse number	2	9d. Date signed (Month			
10) Rt	a completed occurs of do-th	(Itom 22a) /T:-	n Drint)	758		9/28/			
2 IN		30. Name and address of person wh	N 1 1	(Rom Zoa) (Typ	10 CE	NTER DRIV	E, BETHE	SDA, MD 208	92		

State of Maryland / Department of Health and Mental Hygiene

				State of	iviai yiaila /		ificate of		F	Reg. No		3281	2 1
			1. Decedent's Name (First, Midd	tle, Last)					2. Date of Dee	oth Dey	Year	3. Time of De	5âth ¹
	Physicia /Medic	_	Alice Mildred	Gorton						er 29 2	004	8:15 A	4M
	Examin	_	4a Fecility Name (If not institution					4b. City, Town, or I					
		Á	Calvert Manor 5. Social Security Number		ne Age (In yrs. last b	(ایرمای طامت	If Under 1 Year	Rising If Under 24 Hrs.	Sun 8. Date of Birth	Ceci		lace (Stete or Fe	Corpian
	Funeral Director		035-05-3536 Usuel Residence of Decedent	10 M 20 F	91		Months Days	Hours Min.	Month, Day July 7	/, Yeer)	MA	ry)	
	eth with the Marylend 23a or 28a-f show ust be notified at		10a. State 10b. Count	•	10c. City, To						10	0d. Inside City L	
	28a-1	Funeral Director	MD Ce 10e. Street end Number	cil	Rus	sing S	10f. Zip Code			10g. Citizen of V	Vhat Count	try?	
	with with	흐	53 Carter Road	,			219	11		us			
	me 23	Pera	11. Maritel Status	12. Was Deced		13. Wa		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		e - America		
21215-0020	72 hours efter deeth with the Marylend naturel: or frems 23a or 28a-f show dical Examiner must be notified at	2	1 ☐ Never Married 2 ☐ Me 3 ☐ Widowed 4 ☐ Divorce	M Von Civo	□ X No		res, specify Cub □ Yes 2 💢 No		o Hican, etc.)	Specify	k, White, c		ŀ
2-0	72 ho	Completed	15. Decede	nt's Education est grede completed)	16	a. Deceder	nt's Usuel Occup	oation during most of wor d)	king	16b. Kind of Bu	siness/Ind	lustry	
2	within ene.	npie	Elementary/Secondary (0-12)		lor 5+)			d)		Δ			
121	Hygier Hygier ther th		17. Father's Neme (First, Middle	/ not)		Home	emaker	18 Mother's Nar	ne (First, Middle,	Own H			
Maryland	Suld be fi Mentel H arked off	ă		s, Last)				Mabel		maraoti parriani	~/		
Ž	d Mei d Mei mark	၉	Howard McLeod 19a, Informant's Name/Relation	ship (Type, Print)	15	9b. Mailing	Address (Street	and Number or Ru		or, City or Town,	Stete, Zip	Code)	
E	od 2 s Ith en 27 is 1		Mildred Carter					Road, Ris					
	f Hea	1	20a. Method of Disposition		20b. Place		tion (Name of tory or other pla		Date	20c. Location -		wn, State	
E O	Peges nent of I int: If ite		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation _5 ☐ Other (ate			Cemetery	10-6-04	Colon	a. Ma	vruland	
Baltimore,	permit. Peg Depertment Important: If eny Injury o		21. Sig III & Funeral Service	-	West		Name and Addre		T. Foard			-	
ä	Pe e e		Much t.	In the		111	S. Que	en Street				Contractor Contractor	-
			23a. Part. Enter the diseese, slock, or heart failure. Lis	or complications that cause on eed	used the death. Do	o not enter						Approximate Interval Betwee Onset and Dea	en ath
뭐	Physician /Medical		Immediate Cause (Final disease or condition	Pris	ump L21							5-7 da	
3.7	Examiner	1	resulting in death)	a	Due to (or as a Due to (or as a	a conseque	ence of):	0		0	-		.42.
	p ii	iner		- Chri	ONIC (Obsta	ructive	Pulma	PARY	Distus	e	year.	5
	icete be executed physician end s the buriel-trensit	Examiner	Sequentially list conditions,	0	Due to (or as	a conseque	ence of):						
68760,	be ex ician buriel	alE	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
387	g phys es the	edicai	resulting in death) Last		Due to (or as e	conseque	ence of):						
Box (certifi ding use es	Ž		d									
m	death cert a attendin d for use	Icia	Part II. Other significant condit	tions contributing to dea	th but not resulting	in the und	derivina cause di	ven in Part I.	23b. Did 1	obacco use cor	ntribute to	the cause of o	death?
P.0	The law requires thet the death certificete be executed ste hes been signed by the attending physician end page 2 should be deteched for use es the buriel-trensit	Physician/M	Dementi a	A 1			Time		1 🗆 '	Yes 2 No	3 Prot	oably 4 □ Un	nknown
Ś	es the igned be det	by	Dementia	VC Pol	zhei mei		ight				T 645 146		dia - a
Record	v require been si should I	Completed								an eutopsy rmed?	ava	ere autopsy find ailable prior to mpletion of cau:	
ec	hes by	nple									of e	death?	
E									101	res 2 por	1[]Yes 2□ No	0
Vital	certificate	Be	25. Was case referred to medic examiner?	Hospital:			- C - c . Ot		ath (Check only o				
o	S .0 0	٦ ا	1 ☐ Yes 2 No 27. Menner of Death	1 U In		Outpatient o. Time of	3□ DOA 28c. Inju	4 Nursing F	lome 5 ☐ Resid	now injury occur		"	
on	ding th. After	tion	1 Naturel 5 Pend 2 Accident inves	28a. Date of (Month)	, Dey Year)	Injury		rk?]Yes 2∐No					
Division	Attending er death. rector: Afte by the fune	Certification:	3 ☐ Suicide 6 ☐ Coul-	mined 289. Place	of Injury - At home, g, etc. (Specify)	farm, stree	et, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	l Route Numbe	ЭГ,
	res eft												
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)	ring Physician: To the basi Examiner: On the basi and manner	is of examination	ge, death o and/or inve	estigation, in my	me, date and place opinion, death occu	r, and due to the irred at the time,	date and place,	and due to	the cause(s)	
	Vithin Fo the	Me	29b. Signature and title of certif	ier			29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	
			> Will	2 hall			Do	75839	54	9/29/1	74		
	1		30. Name and address of person	n who completed cause				IL LA	MIN N	19			
_	- 1		101 Cou	DNIAL WA		sine	1 Sun	, WO	219	((
	Sta	te	31. Date filed (Month, Day, Yea	32. Re	gist Signeture		-						

DHMH 16 Rev 6/95

			1 - For State of Maryland / Department of Mary	artment of Health and Me rtificate of Death	ental Hygiene	00000	
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death	
	/Medic	al .	Helen Marie Geesey 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Sept 29, 2004 4:55 A		
	Examin	er	7906 Veltri Drive	Fort Washington		rince George's	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F 67 Yrs. 172 30 2612	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Yeer, May 23, 19	9. Birthplace (State or Foreign Country) Pa	
	and DW		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits	
Baltimore, Maryland 21215-0036	Mary I-f sh	To Be Completed by Funeral Director	Maryland Prince George's Fo	rt Washington		1 ☐ Yes 2 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hyglene. Important: If tier 27 is marked other then "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Evans has must be notified at once.		10e. Street and Number 7906 Veltri Drive	10f. Zip Code 20744	2.1	itizen of What Country? .ted States	
			1 Never Married 2 Married 1 Yes 2 7 No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2万No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
			15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	7	Kind of Business/Industry	
			17. Father's Name (First, Middle, Last) Francis Lingenfelter	18. Mother's Name	First, Middle, Maider Marie McCl	n Sumame)	
	and 2 shou alth and M 127 is mar ar traumat			ng Address <i>(Str</i> eet an <i>d Number or Rural</i>) Mojarro Court, Wai			
	of Her of Her if item		20a. Method of Disposition 1 Burial XXCremation 3 Removal from State 20b. Place of Disposemetary, creations,	osition (Name of Da matory or other place)		ocation - City or Town, State	
	Pag tment tant: I		'4 □Donation 5 □ Other (Specify) Lee Cren			nton, Maryland	
Bai	permit Depar Impor eny in		10 D. / Mgs MO1340	2. Name and Address of Facility Lee Alexandria Ferry Ro	d, Clinton		
The second	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listes of Mur), that initiated events C.	озричногу итозг,	Approximate Interval Between Onset and Death		
	e death certificate be executed he attending physician and ted for use as the burial-transit	Physician/Medical Examiner		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
	law requires that the de as been signed by the s 2 should be detached f	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the u		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4/5/Unknown		
	To the Hospitel or Attending Physician: The law requivithin 24 hours after death. To the Funerel Director: After this certificate has been completely filled in by the funeral director, page 2 should				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?	
Vital		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X Sio Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (- 50	
of		ledical Certification; To	1 Yes 2 Name of Death 1 Natural 5 Pending 2 Nacident Accident 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	of 28c. Injury at Work? M 1 Yes 2 No	28c. Injury at Work? 28d. Describe how injury occurred		
Division			3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	reet, factory, office	If. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)	
			29a. Certifier (Check only one) 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	To T com	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Dey, Year)	
<u></u>			Oheren m Cwo	0101840404	Sex	or 29, 2604.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theresa Cusco, MD, Malcomb Grow Medical Center, AAFB, Camp Springs, MD							
	State Registrar 31. Date filed (Month, Day, Year) 32. Restrar's Signature 32. Restrar's Signature						

			For State Registrar	State of Maryland	d / Depa		lealth and N	/lental Hyg	_	L 32823	
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	3. Time of Death	
	Physicia		SHIRLEY MAE	GREENFIELD				Month Septemb	er 23,20	Year 104 9·10 Δ M	
	/Medic xamin		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of Death		4c. County o		
_	Admini		6000 SARGENT ROAD #			Hyatts	ville		Prince	George's	
Fu	neral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			
Dir	ector		578-48-7572 1□ Usual Residence of Decedent	M 2X F 81	Yrs.	Months Days	Hours Min.	June 17	,1923 V	Vashington,D.C	
death with the Maryland	of show		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
Mar		to	Maryland Prince Geo	rge's Hv	attsv	ille				1 X Yes 2 □ No	
the s	128	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	hat Country?	
, wit	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic avant, It a Modical Exercitive Franciscolar once.	<u>=</u>	6000 Sargent Road	#106			20782		U.S.	. A .	
deat		Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race		
afte o			1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2XXNo If Yes, Give	1	1 ☐ Yes 🏖 No	Specify:	nican, ecc.		, white, etc.	
hours at	2	ξ	3 XWidowed 4 □ Divorced	ed 4 Divorced Year or Dates:		TO 165 25 NO Specify.			Specify: Black		
IIIQ Z IZ I 3-0030 be filed within 72 hours after ital Hygiene.		Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	rina	16b. Kind of Bus	iness/Industry	
v ₹ .	E W	ם	Elementary/Secondary (0-12)	College (1-4or 5+)							
M be will	31	ပ်	12th	+02	Stat	icial Cle					
VIATION WILLS THE THE MENTAL HIS	van Van	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's Nam		Maiden Sumame	year 004 9:10 A. Year 004 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 9:10 A. 10d. Inside City Limit 1 Yes 2 N What Country? A. a- American Indian, k, White, etc. Black Isiness/Industry 1 Institute 9 State, Zip Code) A. 20782 City or Town, State e, Md. h., DC 20001 Approximate Interval Between Onset and Death Onset and Death Approximate Interval Between Onset and Death Probably None autopsy findings available rior to completion of cause of leath? 3 Probably None autopsy findings available rior to completion of cause of leath? Yes XXNo or (Specify) and due to the cause(s)	
Ment	arke stic 8	၉	Howard S. Grant,	Sr.			Ida Ro	gers		, <u>.</u>	
Mar d 2 sho th and			19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Numbe	r, City or Town, S	tate, Zip Code)	
and and	n 2/ ertr	1	Judith C. Greenfiel	d/daughter	6000	Sargent I	Road #106		ville,Ma	1. 20782	
ore, es 1 ar of Hea		1	20a. Method of Disposition 1 ☐ Burial	20b. Pl	ace of Dispo	sition (Name of natory or other plac		Date 4/04	20c. Location - C	city or Town, State	
Dailimor	ייין פעיו	1	'4 □Donation 5 □ Other (Specify)	Riv	erdal	e Park Cı	rematory		iverdale	Md.	
Parti	rie in		21. Signature of Funeral Service License	, ,	F 22	2. Name and Addre	ss of Facility uneral H	ome Inc			
a a a	any ir		De Shown S. To	attis mois			Island Av			n. DC 20001	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate	
Provide	nysician /Medical xaminer		Immediate Cause (Final								
			disease or condition resulting in death) a. Atherosclerotic Heart Disease Due to (or as a consequence of):								
Exan											
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):						
petn	ansit	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events c.								
be executed	n an ial-tr	Examiner	resulting in death) Last	Due to (or as a consequ	ence of):						
te be ex	sicia	cal	d								
ificat	s the	ba									
ath certi	ngung nse s	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnar					23d. Date	of delivery	
eath 6	for i	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de]Ectopic pregnancy] Other <i>(specify)</i>	,		Mont		
) §	ng Physicien: The law requires the this certificate has been signer and director, page 2 should be deneral director, page 2 should be deneral director.	ıysi	9 Unknown	9□ Unknown		1, 2,					
r ta			Part II. Other significant conditions cont					bacco use contrib	co use contribute to the cause of death?		
		d by						1 🗆 Y	Yes 2□No 3□Probably ♣️Unknown		
		Completed						24a. Wasa	245 146	na automo findina avalabla	
Hecords,		d m						autops perfor	sv pri	or to completion of cause of	
. F								1 ☐ Yes	2 🔼 No 1 🗆		
VILAI icien: T		Be	25. Was case referred to medical examiner?	penital:		Oth	00	Peath (Check only one)			
Phys		ို	27. Manner of Death 1 A Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at Work?						5 ♣ Residence 6 ☐ Other (Specify) Describe how injury occurred		
E 6		o						28d. Describe no			
VISION Attending r death.	the 1	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Division Alter			Yes 2 □ No	006 1			
or A	in by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, iarm, str	eet, factory, office		City or Town	Bf. Location (Street and Number or Rural Route Number, City or Town, State)		
oite urs a	pell led										
the Hospitel or	within 21 hours after death. To the Funerel Director: A completely filled in by the fa	edical	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the within		Me	29b. Signature and title of certifier 29c. License number			e number	29d. Date signed (Month, Day, Year)				
	4		1 erea a	lle		Do	034795		10-1	2004	
10 1	(1)		30. Name and address of person who con	npleted cause of death (Item	23а) (Туре,						
r (3		Teresa E. A	llen. MD - 0	5525 B	elcrest 1	Road Hva	ttsville	. Marvla	and 20782	
	Sta	te	31. Date filed (Month, Day, Year)	P. Registrar's Signati	ure		*****		J LC		
F	legistr		OCT 04 2004	Elder K	Anne	le le					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 27,2004 Month **Physician** September 5:05 a M Lorraine W. Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Ft. Washington
If Under 1 Year If Under 24 Hrs. Millennium Health Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Min. Months Hours 1 □ M 2√□ F 20, 1923 Director Feb. Virginia 81 227-22-7889 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, it a Madical Exactified in any pure. 1 Yes 2 No Ft. Washington Funeral Director Maryland Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20744 12021 Livingston Rd. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gracie Edwards ဂ Willie G. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2911 Eagles Nest Dr. Bowie, Md. 20717 Wilmer Smith / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oct.1,2004 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. Lincoln Memorial 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 20747 21-Signature/of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reunione Physician /Medical Due to (or as a consequence of) **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed and Due (o as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2 No or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 No 2 ER/Outpatient 3 DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred er of Death 28b. Time of 28c. Injury at Work? 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of gleath (Item 23a) (Type, Print) M.D. 7700 Old Branch Ave. S-101 Clinton, Md. Laxmi N. Berwa, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 0 2004 Registrar

			Amend Item	n 29d per ph	ary G8	3/ 99 C	<u>partme</u> nt ertificate	e of	tealth and Death	Mental Hy	/giene	NL	32825
			1. Decedent's Name (First, Middle	, Lest)	-					2. Date of D	eeth Day	Year	3. Time of Death
	Physici		NATHANIEL	HARRELL						SEPT.	30 200		9:30AM
	/Medio Examin	_	4e Fecility Name (If not institution	, give street end number)					4b. City, Town, or	Locetion of Dea			
	LXum	Ü.	CIVISTA ME	DICAL CENT	פקי				LA PLAT	' Δ	CHAR	T.FS	
	Funeral		5. Sociel Security Number		e (In yrs. i	est birthde	y) If Under		If Under 24 Hrs	8. Date of B	irth		place (State or Foreign
	Director		578-22-0134	Ж М 2□ F	79	Yrs.	Months	Days	Hours Min.	July 9		Virqi	mia
	~		Usuel Residence of Decedent							July	1325		
	ylan		10a. State 10b. County			, Town or	Location					1	Od. Inside City Limits
	Ma	햦	MD Pr Geo	Co	Cli	nton							1 □ Yes 🍇 No
	7 28 H	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of	What Cour	ntry?
	h wii	<u>e</u>	9311 Pella Pla	ce			207	35			USA		
	within 72 hours after death with the Maryland ene. Than "naturel", or items 23s or 28e-f show the Medical Examiner must be retified a	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,	S. 1	3. Was Decede	ent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N		ce - Americ	
0	after or its		1 Never Merried 2 Marri				1 □ Yes 2		Specify:	to ritoan, otc.)			etc.
21215-0020	ours	5	3 ☑ Widowed 4 ☐ Divorced	Year or Detes:			10 103 2	. <u></u>	opoury.		Specil	Bla	ick
5-0	72 h	Completed	15. Decedent (Specify only highes	's Education		16e. De	cedent's Usual	l Occup k done	ation during most of wo	rkina	16b. Kind of B	usiness/In	dustry
7	thin thin	ᅙ	Elementery/Secondary (0-12)	College (1-4or 5	5+)	life	a. DO NOT use	e retire	during most of wo d)	· ·			70
2	i gien	등	12			Fire	Fight	er			D C Go	vernn	ent
D D	be filed tal Hygi d other event,	Be	17. Father's Neme (First, Middle,	Last)					18. Mother's Na	me (First, Middl	e, Maiden Surnar	ne)	
/a	should b nd Ment marked umatic e	2	Freadmond Harre	:11					Allean	Jacobs			
Maryland	2 sho end I s me		19a. Informent's Name/Relations	hip (Type, Print)		19b. M a	ailing Address	(Street	and Number or R	urel Route Num	ber, City or Town	, State, Zip	Code)
	alth alth	l	Bruce Harrell	Son		Alternative Contractions		-	ace., Cl	inton, l	4d. 2073	5	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hydione. Depertment of Health and Mental Hydione. Timportant: If term 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other traumatic event, it is Medical Examinal mast be notified at ance.	- 1	20a. Method of Disposition	2 Dameur Liver State	20b. Pl	ace of Dis	sposition (Nam crematory or ot	ie of her pla	сө)	Date	20c. Location	- City or To	own, State
Ĕ	Pages nent of int: if Ita iry or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)			_	coln Ce		1	10/8/200	4 Brent	wood.	Md 20722
景	permit. F Depertme Importan any Injur		21. Signature of Funeral Service	Licensee			22. Name and				neral Ho		
Ö	Depending of the sany li		A:00:0 6	2-00 11		-	6503	old	Branch A	Ave. Ter	mple Hil	ls, M	d. 20748
		Н	23a. Part1. Enter the disease, or	complications that caused	the death	. Do not						-	Approximate
1	Physician		shock, or heart failure. List	only one cause on each li	ne.		1.		11			1	Interval Between Onset and Death
1	/Medical	Н	Immediate Cause (Final	(hv	1	DI	211 /	mI	Onan	11 /	11/11	10	Quello
	Examiner	1	disease or condition resulting in death)	a	Due to (or	25 2600	sequence of):	100	1	7 , ,	C(1W)	<u></u>	1 (
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	icate be executed physician and s the bunal-transit	edical Examiner	Sequentially list conditions	b	Due to (or	as a con	sequence of):	1	1			1	2 11 1
ó	ficate be exect physician and the bunal-tra	EX	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying	/);	50	om	MA	12	ON TI	2411	MSG11	ar	(Ddaula
68760,	te be ysici	Cal	Cause (Disease or injury that initiated events resulting in death) Last	c. 1	Due to for	as a cons	sequence of):	17	1	11700	100204		congua,
	= D 0		resulting in death) Last	41	3/1	nn	ina	' /	INN	1 Cer		1	>2mont
Box	andir use	by Physician/M		d. / []			, , , , ,	4	001				0-11-0-717
Ω.	deat e att	2	Part II. Other eignificant condition	ns contributing to death b	ut not resu	Iting in the	e underlying ca	ause giv	en in Part I.	23b. Dio	I tobacco use co	ontribute to	the cause of death?
P.O.	by the	hys	2. GRA 64 WOL							10	Yes 200	3 ☐ Prol	bably 4 Unknown
'n.	s tha	چ											
Ĕ	v requires that the death certif been signed by the attending should be detached for use e	교								24a. Wa	s an autopsy formed?		ere autopsy findings eilable prior to
၀	w rec	Set								per	omea:	co	mpletion of cause death?
æ	he te e has age 2	Completed								1	Yes No	1 [∃Yes 2□ No
ā	Attending Physician: The lew requires that the death cert robath: **coath.** **actor: After this certificate has been signed by the attending ector: After this certificate has been signed by the attended for use is the funeral director, page 2 should be detached for use is the funeral director.	Ö	25. Was cese referred to medical						26 Place of De	ath (Check only	onel		
5	cert	o Be	examiner?	Hospital:	ont 2□1	ER/Outpa	tient 3□ DO	Δ Oth	ner.		idence 6 Oth	ner (Specif	(v)
o o	Physical distriction	7	27. Manner of Death	28a. Dete of Inju	iry	28b. Time		Bc. Inju			how injury occur		y /
0	Affe Pung	ţ	1 Natural 5 □ Pendin 2 □ Accident investig		y Year)	Injur	y M		rk? Yes 2∐No				
S	utten deal ctor: ctor: y the	fica	3 Suicide 6 Could i	not be 28e. Place of Inj	ury - At ho	me, farm,	street, factory,	, office			(Street and Num	ber or Rura	al Route Number,
Division of Vital Records,	after after Dire	Certification:	4 ☐ Homicide	building, et	c."(Specify)				City or 10	iwn, Stete)		
	spita nours neral	alc	29a. Certifier 1 Certifyin	g Physician: To the best,	ef my knov	vledge, de	ath occurred a	at the time	me, date and place	and due to the	cause(s) and m	anner es s	teted.
	• Ho • Fu • Fu	edical	(Check only a Medical !	Examiner: On the basis of and manner st	f/examinat ated.	ion and/or	r investigation,	in my c	ppinion, death occu	urred at the time	, date and place,	and due to	the cause(s)
_	To the Hospital or Attending Physician: The lew within 24 hours after death. To the Funeral Director After this certificate has a completely filled in by the funeral director, page 2.	M	29b. Signeture and title of certifier	- I Wh	110	_	A		se number		29d. Date sign	d (Month)	Day, Yeer)
	(3)		> ALAR	W NIM	Um	431	40	D-C	060181		4/5	8/15	<u>/10</u> -1-04
	(1)		30. Name end eddress of person	who completed cause of d	leeth (Item	23a) (Typ	oe, Print)				110		
	9		STACIE GUMP	MD 12070		LIN		TER	WALDOR	RF MARY	LAND 2	0602	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registro	er's Signat	ure					-,		
4	Registr		OCT 0 4 2004	Here is the	1	ast.	,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Anna Mae 8:30A M 2004 Heppner October 0 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 8. Date of Birth (Month, Day, Oct. 2, If Under 1 Year Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1□ M 2XF Months Hours Min. 156-05-2100 85 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other then "naturel", or items 23s or 28e-f show treumatic event, the Modical Examinst must be notified at 1 TYYes 2 No Director N. T Hudson Union City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene.
Int: If item 27 is marked other then "naturel", or Items 23s or? 413 18th Street 07087 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: þ white 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Embroidery 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fabric Industry Examiner Fabric Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John A. Kenny Mary Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is George C. Heppner(son) 6648 Sitio Palmas, LaCosta, CA 92009 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 10/5/2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery North Arlington, NJ 22. Name and Address of Facility Beall Funeral Home 21 Signature of Funeral Service Licenses any ir 6512 NW Crain Hwy. Bowie, MD m. I 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a Wasan certificate has autopsy luo 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Certification: 1 Natural 2 ☐ Accident 5 Pending investigation death. Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certified cal (Check on one) and manner stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADITYA CHOPRA, M.D. 600 RIDGELY AVE STEZZI ANN APOLIS, MD. ZILLOI 31. Date filed (Month, Day, Year) State OCT 04 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Month Year **Physician** John William Howell September 30,2004 10:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 265 Irishtown Road North East Ceci1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. 1**X**M 2□ F Months Hours Director 55 1948 Maryland Dec. 25, 220 50 0018 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes XXNo Director Maryland Cecil North East 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 265 Irishtown Road United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 1 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Concrete Finisher Construction markad othar othar traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental P should be Jesse Nolan Howell, Sr. Lucille Randolph Hypes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 so of Health an Jessica Hines/Daughter 45 Hill Top Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ortant: If i 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Oct. 5,2004 Newark, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 21. Signature of n al Service Licen 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21921 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician urrhosis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of): burial-Box 68760, attending physician Physician/Medical d. the IF FEMALE: 150 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 🗆 No 1 🗀 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 **X** No 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attanding 5 Pending investigation Natural 1 🗌 Yes death. 2 No 2 Accident Diractor: 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined after 4 Homicide within 24 hours a To tha Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Am-cer Man MD Dood 4823 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIH ISU MD 223 32. Registrar's Signat State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** 23 2004 Verna E. Harrison 9 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Nursing Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 220-26-1374 72 years Yrs. Easton, MD Director 9-15-1932 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral, or items 23a or 28e-f show Examiner and be notified at 1 ☐ Yes 2 ☐ X9o Talbot Tilghman Directo MD10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21582 Bar Neck Cove Rd. 21671 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or fler any injury or other traumatic event, the Medical Examinal once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyWhite Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 5 Merrell H. Evans Margaret Ann Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Harrison (daughter) 9601 Macks Lane, McDaniel, Md. 21647
Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) John's Cemetery 9-28-2004 Tilghman, MD. R. Carroll Hurley Funeral Home, PC 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death renv Immediate Cause (Final disease or condition resulting in death) ATheroscle, The heart **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending f IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate 1 Yes 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funaral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2NL 500 Macommuns 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

_			Certificate of Death	Reg. No.	32829
	Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Deeth Month Dev Ye	3. Time of Death
	/Medica	EIREL LAVENIA HICK		September 20, 20	004 8:45 Pm
	Examine			r Location of Death 4c. County of I	Deeth
		6498 Rock Hall Road	Rock Ha		
	Funeral Director	0. 0303	last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir	n. (Month, Dey, Year)	Birthplace (State or Foreign Country) ryland
	and **	Usuel Residence of Decedent 10a. Stete 10b. County 10c. Ci	ty, Town or Location		10d. Inside City Limits
	he Maryi 28a-f eho primed a		k Hall		1 ☐ Yes 21 No
	after death with the Ma or frems 23a or 28a-fe riner must be notified	10e. Street end Number 6498 Rock Hall Road	10f. Zip Code 21661	10g. Citizen of Wha	t Country?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or frems 23s or 28s-f show any Injury or other traumatic event, the Medical Evarriner must be notified at DRG.	11. Marital Status 1 □ Never Married 2 □ Merried 1 □ Never Married 2 □ Merried 1 □ Never Married 2 □ Merried 1 □ Yes, Give Year or Dates:	I,S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.) 14. Race - / Black, V Specify: P	American Indian, Vhite, etc. lack
5-0	led within 72 hours s ygiene. Ygran "natural", o rt, me Medical Evan	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation	16b. Kind of Busine	ess/Industry
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Mai	hend hend ls m	19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F		
6	1 and Health am 27 ther tr	Loretta Freeman- Daughter	21710 Lovers Lane, Ro		
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ţ	tment tant:		ron Chapel Church Cem.		, Maryland
Baltimore,	permit. Page Department of Important: If any Injury or phos.	21. Signature of Funeral Service Licensee	22. Name and Address of Fecility Bennie Smith Fu	neral Home	
	00=00	Bleek		et, Easton, Maryla	nd 21601
		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Physician				Onset and Death
1	/Medical Examiner	Immediate Cause (Final disease or condition	TAIL UILE		
		resulting in death) a Due to (co	or es e consequence of):	· · · · · · · · · · · · · · · · · · ·	
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			For State Registrar	State of	Marylan		artment o			lental Hy	giene Reg. NQ. 0	4 3	12831
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Baltimore,	permit. Departr Importe eny Inje		21. Signature of Funeral Service	Licensee		22	2. Name and Murie	Address of	Barber	Funera1	Home		
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lon	nding Fith. :: After	atlor	1 □Natural 5 □ Pendin 2 ■Accident investi	9	, Day Year)	Injury 4:5	AM	Work?	2 No	driver	usion	Kup	mach
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Ö	s afte	Certification;	4 Homeda	Buildin	g, etc. (Specify	Stree	>t			7891	nersh	152	TO DE
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Diractor: A completely filled in by the fu	edical	29a. Certifier 1 Certifyir (Check only 2 V Medical	g Physician: To the l Examiner: On the ba	oest of my kno	owledge, deat	h occurred at	the time, da	ate and place,	and due to the	cause(s) and man	ne as stat	ed. ne cause(s)
	To the P within 24 To the F complete	Med	one)	and mann	er stated.			License nun			29d. Date signed		
N	To Cor	-	29b. Signature and title of certifie	121	\mathcal{O} .		290. 1						
	20		36. Name and address of person	who completed assured	Olonib /lbr	, 23a) (T	Print'	0.0	C.M.E.		Septembe	r 29,	2004
,	1		36 Name and address of person	Vanica -	RIIA	n 23a) (Туре, И 11		Str	eet. Ba	ltimore	, Maryla	nd 21	201
	Sta	ate	31. Date filed (Month, Day, Year)	-	gistrar's Signa	ature La	1						
	Regist		OCT 01	2004	eneral	13	spa	KS					

			Avnend 1 - State Registrar	State of N	Per th 3845 Maryland PDepa Cea	7-16-0 artment c rtificate			nd Menta		ene		32832
	Physici	an	1. Decedent's Name (First, Middle, Las	*					Mo	ite of Death	Day	Year	3. Time of Death
	/Media	cal		Johnson	-1	4h Cib. Ta				pt 28	1		9:28 P M
	Examir	ıer	4a. Facility Name (If not institution, give Civista Hospita		7)	4b. City, Tov LaP1a		cation of	Death		Char	y of Death	
	Funeral		5. Social Security Number 6. S		Age (In yrs. last birthday)	If Under 1 Y	ear If	Under 24		te of Birth		9. Birtho	place (State or Foreign
	Director		577-36-8297	X M 2□F	75 Yrs.	Months D	ays H	lours	Min. (M. Jul	onth, Day,	1929	Wash	ington DC
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ncation				111			10d. Inside City Limits
	Maryla f sho	ō	Maryland Charles		Wald								1 □Yes 2XNo
	28a-	rect	10e. Street and Number			10f. Zip Co	ode			10	g. Citizen of	What Cou	ntry?
	th with	al D	6014 New Fore	st Ct. Ap	ot. #4	20	0603					U.S	.A.
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Evan	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 X Yes 2 [If Yes, Give Year or Dates	IN∘ 1950-	Was Decedent If Yes, specify		nic Origi Mexican, pecify:	in? (Specify Yo Puerto Rican,	es or No- etc.)		ce - Americack, White,	
21215-0036	2 hou	ted t	15. Decedent's Ed	ducation	16a Dece	dent's Usual O	ccupation	1		1	6b. Kind of E		
215	thin 7:	Completed	(Specify only highest gra	de completed) College (1-4c	r5+)	kind of work d DO NOT use n	,		of working		_		
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Maryland	should be filed within and Mental Hygiene. s marked other then aumatic event, the M	Be	17. Father's Name (First, Middle, Last) William E. Johns				18.		s Name <i>(First</i> othy L			me)	
Ty.	should id Mei mark matic	2	19a. Informant's Name/Relationship (19b. Maili	ng Address (Si	treet and					. State. Zin	Code)
	and 2 sealth ar n 27 is		Doris A. Johnson		601	4 New 1	Fores	st C	t. Apt.	. #4 V	Váldor	f, Ma	ryland20603
ore,	of Head		20a. Method of Disposition 1X Burial 2 Cremation 3	Damauel from Star	20b. Place of Dispo	sition (Name o	of r place)		ct. ^D 架,		0c. Location	- City or To	own, State
Ē	Pages ment of H ant: If its ury or of		'4 □ Donation 5 □ Other (Specify		Maryland					004			, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene-Important: If item 27 Is marked other then any injury or other traumatic event, the Magnes.		21. Signature of Fuperal Service Licer	ele no		2. Name and A 633 01					cal Ho oad C1		, MD 20735
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	your dial	er the mode of	f dying, su	the as ca	ardiac or respi	iratory arre	st,		Approximate Interval Between Onset and Death
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	STATE OF	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a consequence of):)1	X	7		0	1.	1000	
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60,	ate be executed thysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or a	HALOM	mo	D				,		
09289	physi s the b		•	d	My barraik	20(1.							
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	⊒Ectopic pregn] Other (s <i>pecit</i>						ate of delive	ery Day Year
Р,	res that the igned by be detact	y Pt	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	nderlying caus	se given in	Part I.	2:	3e. Did toba	acco use cor	tribute to t	he cause of death?
Records,	w require been sig should b	ed b								1X Yes	2 □ No	3 🗌 Prob	oably 4 Unknown
eco	e law requ has been je 2 should	Completed							24	ta. Was an autopsy	24b.	Were auto	ppsy findings available impletion of cause of
E B		Com							1 [perform	ed? _4No	death? 1 🗌 Yes	2 X) No
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of	Phys r this ral dir	: To	1 ☐ Yes 2 X No 27. Manner of Death	ı X _ Inpa				4 🗌 Nurs	sing Home 5		ce 6 □Ot v injury occu		(y)
on	Attending I ir death. ector: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Ir (Month, L	Day Year) Injury	М	Injury at Work? 1 Yes	2 🗌 N			,,		
Division	I or Attendii after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of building,	njury - At home, farm, sti etc. (Specify)	reet, factory, of	ffice			cation (Stre ty or Town,		ber or Rura	al Route Number,
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	To the Ho within 24 I To the Fu completely	×	29b. Signature and title of certifier	21	Dog do	29c. Li	icense nu	mber	1	29	d. Date sign	ed (Month,	Day, Year)
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,	15 11 2		30. Name and address of person who								7	, ,	
i	* 11/51	l e	Glenn R. Edgecon 31. Date filed (Month, Day, Year)	1be, M.D.	7700 Old Br	anch A	ve, I	B-20	1, Clir	nton,	Mary1	and	20735
	Sta Regist		0CT 0 1	2004	strar's Signature	GOSAGE!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 9846 8-15-05 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Juanita Kirkland 9:02 P M September 27, /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Md. Hospital Center Clinton Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 22 (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 1 F Months Days Hours Min 579-58-3221 Director 61 August 23, 1943 Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 Is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, In Medical Ferrical Pages. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Funeral Director 1 ☑ Yes 2 ☐ No Md Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10310 Springwater Lane 20772 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes, Give 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Specify: Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3vrs Secretary Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frazier Bolton Sr. Thelma Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10310 Springwater Lane Upper Marlboro, Md 20772 Date 20c. Location - City or Town, State Rochelle Wages/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemtery 10 -04-04 Brentwood, Md 21. Signature of Funeral Service Licens 22. Name and Address of Facility Capitol Mortuary Inc. 1425 Maryland Ave., NE Wash., DC. 20002 11117 100 23a. Pgrt1. Enter the disease, or complications that caused the death. De hot enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician S.EDS) 7 /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Errier or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physiclen: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? de CARTY 1 ☐ Yes 2 ☐ No Completed 3 X Probabiy 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 this s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 🗀 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P46478

State

Registrar

30. Name and address of person

Surenh

31. Date filed (Month, Day, Year)

OCT 0 1 2004

Surretts 12d.

clinton.

no completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

A-Patelino

			State of Maryland / Dep	partment of Health and Mertificate of Death		ne
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Virginia M. King		2. Date of Death Month Cofo ber	Day, 2004 12:50 Am
	Examin		4a. Facility Name (If not institution, give street and number) Doctors Community Hospital	4b. City, Town, or Location of Death Lanham/Seabrook	ς	4c. County of Death Prince George'
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda. 71 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan. 12,1	9. Birthplace (State or Foreign 933 Maryland
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Md. Prince George Bladen			10d. Inside City Limits 1 ∠Yes 2 □ No
	with the A a or 28a-1 Lee notifi	Direct	10e. Street and Number 4206 58th Avenue	10f. Zip Code 20710		Citizen of What Country?
JG 336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportent: If time 27 Is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Eraminar must be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, B Pack White, etc. Specify:
Finia KING	within 72 houiene. then "nature"	ompieted	(Specify only highest grade completed) (Git	cedent's Usual Occupation ve kind of work done during most of worki b. DO NOT use retired) SEE ASST.	ng	Kind of Business/Industry ealth Care
/A land 2	uld be filed fental Hygi rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) James Reed	18. Mother's Name Janie I	(First, Middle, Maid Bulter	en Sumame)
	ind 2 shou alth and M 27 Is mai	-	- / Baugneez	uling Address (Street and Number or Rura 00 Southern Ave. V	Nashingt	y or Town, State, Zip Code) On, D. C. 20032
V/V Baltimore.	Pages 1 and to the try or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	position (Name of MT at MEMORY ** Al Oct. 8	oate 3,2004 S	Location - City or Town, State uitland, Md.
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ceda	ar Hill :	Funeral Home uitland Md.20746
68760.	Physician /Medical Examiner physician and physician and the prival-transit the prival-transit	dicai Examiner	23. Part 1. Enter the disease, or complications that caused the death. Do not entirely shick, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	OC (ANDIOVASWIA	5	Initerval Between Onset and Death
P.O. Box 6	that the death certificat ed by the attending phy detached for use as th	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Recor	The law requate has been page 2 shou	ompieted	Hypertension Respiratory	Failune	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Becords.	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	To Be C	25. Was case referred to medical examiner? 1	of 28c. Injury at		6 ☐Other (Specify)
Divisio	or Attendir safter death. I Director: Af d in by the fur	ertification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or within 24 hours afte to the Funeral Dir completely filled in	Medicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, date a	and place, and due to the cause(s)
	To with	Σ	29b. Signature and title of certifier Rullinger or we will	DOLS52	0	Oate signed (Month, Day, Year) CTOber 1, Zery
(r (4)		30 Name and address of person who completed cause of death (Item 23a) (Type Pari A. De Vore Mn 4203 G	e, Print) Veensbury Ad H	la attsvil	Le MA 20781
	Sta Regist		31. Date filed (Month, Day, Year) OCT 0 4 2004 Registrar's Signature	aste)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death				
	Cartificata	af	Donth	

		-	State Registrar				Ce	rtifica	te of l	Death	1		Reg. No.	104	32835
			1. Decedent's Name (First,						_			2. Date of De	ath	Year	3. Time of Death
	Physicia		RICHA	20	KING							SEPTEM	BEŘ 2	5 200	4:20PM M
	/Medic Examin		4a. Facility Name (If not ins	titution, give	street and num.	ber)		4b. City	, Town, or	r Location	of Death		4c. Co	unty of Death	1
	LAGITITI	C.	8619 NORTH	BEND C	IRCLE				E	ASTON	1			TALB	OT
	Funeral		5. Social Security Number	6. Sex	x 7	. Age (In yrs.	last birthday,	If Unde	r 1 Year Days	If Under	r 24 Hrs. Min.	8. Date of Bid (Month, Da	rth av. Year)	9. Birth	nplace (State or Foreign untry)
	Director		079-10-8157	11/1]M 2□F	92	Yrs.	Montris	Days	Tiouis		JULY 1	1912	IO	WA'
	v		Usual Residence of Deced												10d. Inside City Limits
	how		10a. State 10b. (County		10c. Cit	y, Town or L								1 ☐ Yes 2 ☑ No
	a Ma	cto	MD	TALBO	T		EAST	ON							
	다 다 6.28	Director	10e. Street and Number					10f. Z	p Code				10g. Citizer	n of What Co	untry?
	th wi		8619 NORTH							L601				USA	
	eems ems	Funeral	11. Marital Status		12. Was Deced Armed For	ces?	.S. 13.	Was Dece If Yes, sp	edent of Hecify Cuba	lispanic Or an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	0- 14.	Race - Ame Black, White	
9	d within 72 hours after death with the Maryland jiene. r than "natural", or items 23s or 28s-f show the Madesi Examiner must be notified at	포	1 ☐ Never Married 2		1X Yes)		1 🗆 Yes	2 X No	Specify	<i>r</i> :		Sp	pecify: TITE	ITE
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aŭ	e da da	Be	FRED MENZO							MA	RY E	DITH MO	LAURY		
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Ba	permit. Pages Department of Important: If it any injury or o						1	${f FELLC}$	WS.	${\sf HELFI}$	ENBEL	N & NEV EASTON	MAM F	UNERAL 21601	HOME PA
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			shock, or heart failu Immediate Cause (Final	e. List only o	ne cause on ea	ach line.									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	-	4.	CHOLA		CATL	CIPUI	UP					
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		7	Sequentially list condition if any, leading to immedia	v, 	b. Due to (or as a consec	quence of):								
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Box	requires that the death certificate be executed then signed by the attending physician and hould be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregi	ant	23c. If yes, out			П г					236	d. Date of del	ivery
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rds	quires n sig	p p										1 🗆	Yes 2 🔀	No 3□Pr	obably 4 Unknown
Vital Records,		lete										24a. Wa	s an	24b. Were at	utopsy findings available completion of cause of
Re	The la	Completed										per 1 Yes	opsy formed? 2 No	death?	_
ta			25. Was case referred to	medical						26. Pla	ce of Deat	h Check on			
>	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 X No		Hospital: 1 □ I	npatient 2	ER/Outpati	ent 3 🗆 l	DOA Ott	her: 4 🗆 N	Nursing Ho	me XX Res	sidence 6 [□Other (Spe	cify)
ō	Phys er this eral di		27. Manner of Death		28a, Date	of Injury	28b. Time	of	28c. Inju Wo			28d. Describe			
on	th: Afte	it lo	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation		h, Day Year)	Injury	М		Yes 2[□No				
Division of	Attending r death. actor: After y the fune	fica	3 ☐ Suicide 6 ☐	Could not be determined	200. Flace	of Injury - At I	nome, farm, s	treet, fact	ory, office	100			(Street and I	Number or Re	ural Route Number,
<u>S</u>	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Medical Certification:	4 Homicide		buildii	ng, etc. (Spec	iry)				1	Ony or 1	own, olato)		
	spite	al C	29a. Certifier 1	Certifying Ph	ysicien: To the	best of my kr	owledge, de	ath occurre	ed at the ti	ime, date	and place,	and due to the	e cause(s) ar	nd manner as	stated.
	e Ho 24 h e Fu letely	dic	(Check only 2 1	ledicel Exam	niner: On the ba	asis of examin ner stated.	ation and/or	investigati	on, in my	opinion, a	eath occur	red at the time	, date and p	ace, and due	to the cause(s)
	To th	Me	29b. Signature and the o	certifier				2	9c. Licen	se numbe	r			,	h, Day, Year)
	F > F 0		1 Wan	til 1	hunter	my			70	057	108		91	27/04	f
			30. Name and address of	person who	completed caus		om 23a) (Typ	e, Print)					-		
			880	S. TA	2 Bos	51	51.	MICH	neis	n	D S	11665			
	St	ate	31. Date filed (Month, Da	y, Year)	32. R	egistrar's Sigr	nature								
	Regis		S	- F 2 y	2004	- Barre	B.	Soan	A.						
DI	IMH 17 Rev 1/	2001			,			-							

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

Christopher C.

31. Date filed (Month, Day, Year)

Dunford MD

2004

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OCT 0

32. Registrar's Signature

ORIGINAL

615 West Montgomery Avenue, Rockville, Maryland

State of Maryland / Department of Health and Mental Hygiene

			1 = State Registrar			Ce	rtificate c	f Deatl	h	Re	g. Ng. 0	1 32837
	Physicial		1. Decedent's Name (First, Midd	. ,						2. Date of Death		3. Time of Death
	Physici /Medic		Irma	La	uster						er 23, 2	
Ž.	Examin		4a. Facility Name (If not institution		-		4b. City, Town				4c. County of [
		5.5	Annapolitan 5. Social Security Number					nnapo1		O Day of Birth		runde1
	Funeral Director		359-05-6406	1 M 2 SF	Age (In yrs. I	Yrs.	Months Day		Min.	Month, Day, June 23	, 1914 Dc	Birthplace (State or Foreign Country) nnybrook, ND
	and		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Manyl	lor	MD Princ	e Georges		Hy	attsvil	Le				1⊠Yes 2□No
	r 28a	Director	10e. Street and Number				10f. Zip Cod			10	Og. Citizen of Wha	t Country?
	death with the Maryland ms 23s or 28s-f show Linual Le rollified at	rai Di	2102 Chapma					783			U.S.A.	
960	be filed within 72 hours after death with the Marylar lat Hygiene. d other than "natural", or Items 23s or 28s-1 ahow avent, I'le Medical Examiner man be notified at	l by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorced	If Yes Give	s? XINo		Was Decedent of If Yes, specify C			cify Yes or No- Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0036	thin 72 hu e. an *natu Medical	Completed		nt's Education st grade completed)	or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use rei	cupation ne during mo ired)	ost of workin	ng	l 6b. Kind of Busin	•
7	filed wi Hygien other th	Con					Teacher	T				ation
land		To Be	17. Father's Name (First, Middle, Gerhardus S	ŕ				18. Mot		<i>(First, Middle, N</i> na Vick	faiden Sumame)	
ary	d 2 should be th and Menta 7 Is marked traumatic so	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Stre	et and Num	ber or Rura	Route Number,	City or Town, Sta	te, Zip Code)
	es 1 and 2 s of Heelth ar I Item 27 Ia r other trau		Barbara Hille	- Daughter		2816	Bay Blv	d Hu	nting	town MD	20639	
Baltimore,	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (3		, a	emetery, cre	osition (Name of matory or other p coln Cem	olace)	_		Oc. Location - City Brentwo	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service								n Funera twood MD	
E.			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that caus	ed the death							Approximate Interval Between
r	Physician		Immediate Cause (Final disease or condition		lem.	onti	0					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ		<i></i>					71
	Cxammer	_	Sequentially list conditions,	b. De	po-es	820r	1					many 422
	be tist	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	7.64	ense						many yrs
	execut n and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or	s a consequ		on					17.3
68760	death certificate be executed e attending physicien and of for use as the burial-transit	Medicai I		d						-		
39 × 0	death certific attending pl		IF FEMALE:	23c. If yes, outcom	ne of pregna	ncv					20.4 D	1 P
P.O. Bo		Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3[⊒Ectopic pregna ⊒ Other <i>(specify)</i>				23d. Date of Month	Day Year
	res thet igned by be deta	y Ph	Part II. Other significant conditi	ons contributing to death	but not resu	ılting in the u	inderlying cause	given in Parl	:L	23e. Did toba	acco use contribut	e to the cause of death?
rds	w requires been sign should be	ed by								1 🗆 Ye	s 2□No 3□	Probably 4 Unknown
Vital Records,	e la has	Completed								24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of h?
ā	(0 -1	e Co	25. Was case referred to medica	nt				26 Bloc	a of Dooth		⊠ No 1□	Yes 2□ No
>	ysician: is certific director,	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 🗆 I	ER/Outpatier	nt 3 DOA	24		(Check only one ne 5 □ Resider		Specify ASST. living
on o	ding Phys h. After this funeral di	tion: T	27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time o Injury	V	njury at Vork?	2		w injury occurred	
Division of	Hospitel or Attending Physician: 24 hours after death. Funeret Director: After this certific tely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of	Injury - At ho etc. (Specify	me, farm, sti	reet, factory, office	> 8	2	8f. Location (Stre City or Town,	eet and Number o. State)	r Rural Route Number,
	Hospitel 24 hours Funeret stely filled	edicai C										
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certific				29c. Lice	ense number			d. Date signed (M	
}	- > - 0		1 0 92.	Y	MI		-	D 40	517		9-29	-04
1	(7)		30. Name and address of person		f death (Item	23a) (Type,	Print)					
1				NUSAIREE			nadiso	n 6 M	zic,	Glens	Busnie,	21061,MD
		198	31. Date filed (Month. Day, Year) 36 Regi	strar's Signat	tura						-

31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

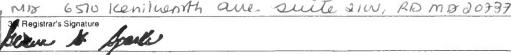
		For State Registrar	State of Maryla	-	artment of F tificate of I		Mental Hy	giene Reg. No.	004	32838
ysicia	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of D Month	Day	Year	3. Time of Death
/ledic		David Sam		vrence			9	29	04	10:30 _a
amin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Riverda		ath	1	ince	^h Georges
eral		Social Security Number 6. S	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of B		9. Birt	hplace (State or Foreig
ctor		217-19-0433	□ M 2 🔆 71	Yrs.	Months Days	Hours Mi	rs. 8. Date of B (Month, D	3/32	Jai	maica
11		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation					10d. Inside City Limit
or other traumatic avant, the Medical Examiner must be radified at	tor	MD Prince	Georges R	iverda	le					1 XYes 2 □ N
19	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	ountry?
9	ral	6605 Oliver St			20737			L	Jama	
	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0- 1	 Race - Ame Black, Whit 	
	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1		1 ☐ Yes 2 🛣 No	Specity:		5	Specify: bl	ack
	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	un dein m	16b. Kin	d of Business/	Industry
	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of w	vorking			
	Con	_10th		cabi	net mak		· · · · · · · · · · · · · · · · · · ·		empl	oyed
	Be	17. Father's Name (First, Middle, Last)	~				ame (First, Middle ste Unk		iumame)	
	은	Carlton Lawren 19a. Informant's Name/Relationship (7)		19b Mailir	ng Address (Street				Town State 2	Zia Code)
		Stephen Lawren		1	•					ID 20783
		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date		ation - City or	
		1 ☐ Burial 2 ☐ Cremation 3 🔀 1 ☐ Donation 5 ☐ Other (Specify		•	r Cemeter		-6-04	Mont	.ego Ba	y,Jamaica
ouce.		21. Signature of Funeral Service Licen			BK Hei		neral C			
됩		tisa ((XRnri	-					ton DO	2000208
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that ceused the de one cause on each line.	th. Do not ent	er the mode of dyin	g, such as card	iac or respiratory	arrest,		Approximate Interval Between Opset and Death
n I	į y	Immediate Cause (Final disease or condition resulting in death)	Lune	g Canc	er					Onset and Death 6 months
l r		resulting in dealin)	Due to (or as a conse	equence of):						
	er	Sequentially list conditions,	b. Due to (or as a conse	equence of):						
	Examiner	Sequentially list conditions, fany, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	c.							
	Exa	resulting in death) Last	Due to (or as a conse	equence of):						
1	dical		d							
	0	IF FEMALE:	23c. If yes, outcome of preg	inancv				25	3d. Date of del	iven
	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fe 4 Pregnant at time of		Ectopic pregnancy Other (specify)	<u> </u>		-	Month	Day Year
	hysi	9 Unknown	9□ Unknown							
	by P	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.				the cause of death?
							1 🗆	Yes 2	No 3⊠Pr	obably 4 Unknow
	Completed						24a. Wa auto	opsy	prior to	itopsy findings availab completion of cause of
	Con						pert 1 ☐ Yes	ormed? 2 🔯 No	death?	2 No
	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only			
	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2	EP/Outpatier 28b. Time o			Home 5X Res			cify)
	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office			(Street and	Number or Ru	ıral Route Number,
	Cert	4 Nomicide	building, etc. (3per	City)			Oily or 10	JWII, JIA(8)		
	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami- and manner stated.	nowledge, deat	occurred at the tin	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s) a	nd manner as	stated. to the cause(s)
	Med	one) 29b. Signature and Authoritifier	an manner stated.		29c. Licens				signed (Monti	
		200. Orgitative and in the service			D0332					
1		30. Name and address of person who	completed cause of death //s	em 23a) /Time			0-11/5	CCLOD	er 4,20	004
1		Frederick P. Smith				i+a 1200	O Chevy	Chace	- Malo	0035
	l	ETECETICE P SHITT			I AVE - SII		U LINEVV		اد تکالاا پ	0815

3 State Registrar

31. Date filed (Month, Day, Year) 2004 04

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arles,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MASTER

050514

10/1/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month September 29, 2004 4:49 A M **Physician** William | Edward Long /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, You 19, Nov. 19, Silver Spring Montgomery

9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** X⊓M 2□F 1947 Virginia Director 223-66-4333 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b Count show "natural", or Items 23a or 28a-f show idical Examiner must be notified at Yes 2 No Completed by Funeral Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with USA 20910 10110 Hereford Place death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int If item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedenl's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Construction 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irene Corbin Herbert Long 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 I 10110 Hereford Place Silver Spring, Maryland 20901 Jacqueline Barber-Long/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot once. 10-9-04 1 Burial 2 Cremation 3 Removal from State Morning Star Bapt.Church St.Stephens Church, Va. ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Frazier's Funeral Home, Inc. 389 Rhode Island Ave., Wash.,DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician a Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Supraventricular Tachycardia Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t d be detact: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Gastric Carcinoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page certificate 1 Yes 2 🕱 No 1 TYes Division of Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dato and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 9-29-04 D58436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road Joshua Kolko, MD Silver Spring, Maryland 20910

State Registrar

31. Date liled (Month, Day, Year)

OCT 0 4 2004

32 Registrar's Signature

		For Unpend Item State Registrar 1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath	Year	3. Time o	
Physicia /Medic		Stanley L. Leg	ggs						\$	eptemb	er 19,	2004	7:40	A M
Examin	er	4a. Facility Name (If not institution, Peninsula Regior	-		ox	4b. City, To	own, or L .isbu		f Death			ity of Death		
				7. Age (In yrs.		If Under 1		If Under a	24 Hrs.	8. Date of Bir				or Foreig
Funeral Director		215-62-2133 Usual Residence of Decedent	1 X M 2□ F	48	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept 20	iy, Year) 6 , 1955_		olace (State ntry) DE	
MOI		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside C	ity Limi
ts 1-9- liffed	ctor	MD Wicomi	ico	Sa	lisbur	У							1 XYes	s 2 🗆 N
or 28	Funeral Director	10e. Street and Number	2 1	4		10f. Zip C					10g. Citizen o		ntry?	
18 23e	eral	306 Maryland Ave	_	• 4 edent Ever in U	I S 13		801	nanic Orio	nin? (Spe	cify Yes or No		U.S.	can Indian.	
f Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28e-1 show other treumatic event. The Medical Examiner must be notified at	ρ	1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed Fo	rces? 2 ⊡ No Δ γ τι	13.7	If Yes, specif		, Mexican Specify:	, Puèrto	ecify Yes or No Rican, etc.)	В	lack, White, city: Wh	etc.	
then "natur the Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1	1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done du	ion uring most	t of worki	ng	16b. Kind of	Business/In	dustry	
ygiene ver the t, the	Com	10				Car	pent					ail S	ales	
h and Mental Hygiene. 7 Is marked other then " Ireumatic event, Ire Me.	Be	17. Father's Name (First, Middle, L									, Maiden Sumi	ame)		
d Mer marke	2	Thomas James Leg	-		19b Maili	no Address (-	n Eskr	lage er, City or Tow	n State Zir	Code)	
Ith an 27 is i		Clara E. Leggs/v									Salisb			301
of Health item 27 I r other tre		20a. Method of Disposition		20b. l						ate	20c. Location			
nent or ant: Iff i		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery 9/24/2004 21. Signature of Funeral Sequice Licensee 22. Name and Address of Facility												
Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service L	icensee		L	ewis N	. Wa	atson	Fun	eral Ho	ome , MD 21	801		
Medical Medical Medical	Examiner	23a. Part Enter the disease, or of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the disease or injury that initiated events resulting in death) Last	a. Cocai Due to (ine and (or as a consec	Amitr quence of): quence of):								Interval Be Onset and	Death
by the attending ph tached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		ointh 2 ☐ Feta nant at time of o	al death 3[⊒Ectopic pre						Date of deliv		Year
been signed should be de	by	Part II. Other significant conditio	ns contributing to de	eath but not re	sulting in the u	inderlying cau	ise given	n in Part I.			tobacco use co Yes 2 ☐ No		V	Unkno
ate has be page 2 sh	Completed									24a. Was auto perfo		prior to co death? 1 X Yes	opsy findings impletion of a 2 No	availa cause
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_		0.1	-		(Check only				
r this ral dii	7: 10	Yes 2 No 27. Manner of Death	28a Date	of Injury	ER/Outpatie		c. Injury a Work?	4 LI NU			dence 6 C how injury occ		fy)	
th. : After thi s funeral o	tlor	1 ☐ Natural 5 ☐ Pending investig	Found	h, Day Year)	Foun	d M	1 □ Y€	? es 2. ⊊ 7l		Unknow				
within 24 hours after death, To the Funerel Director: A completely filled in by the f	Certification;	3 Suicide 6 ☐ Could n 4 Homicide determi	ot be 28e. Place buildi	04 of Injury - At h ing, etc. (Speci 1d in r	nome, fårm, st ify) esiden	reet, factory,	office			28f. Location (City or To	Street and Nur wn, State) Fo	ound.3	al Route Nur 806 Mai	nber,
Funeral Funeral tely filled	edical (29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the Examiner: On the b and man	best of my kn asis of examin- ner stated.	owledge, deal ation and/or in	th occurred at	the time	e, date an inion, dea	d place.	and due to the	cause(s) and i	manner as s	stated. o the cause((s)
et ete	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date sign	ned (Month,	Day, Year)	
within 24 hours after o To the Funerel Direct completely filled in by	PH 3		1		1		_	0.14	T.		C	20	200/	1
within 24 To the F complete		30. Name and address of person v	Halla	n N A	m 23p) (Type,	Print)	0.	.C.M.	C.		Septemb	er 20	, 2004	1

		-	For State Registrar	State of Maryland		artment of H			giene Reg. No. 0 0 4	32842
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month SEPT.	Day Year 22 2004	3. Time of Death 8:45 AM
5 A	/Medic		Mary Joan Leekl 4a. Facility Name (If not institution, give si	*		4b. City, Town, or	Location of De		4c. County of Deat	
	Xumm		725 SPANIARD NECK	ROAD		CENTRE	VILLE		QUEEN ANN	NE'S
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Day	y, Year) 9. Birth	hplace (State or Foreign untry)
" Allie	Director		323-03-4305 Usual Residence of Decedent	93	113.			Oct. 5	, 1910	Ohio
yland	Mow #		10a. State 10b. County	10c. City,	Town or Lo	cation		-		10d. Inside City Limits
e Mai	Sa-f s	Director	MD Queen An	ne's Cen	trev:					1 ☐ Yes 2 ☐ No
deeth with the Maryland	2 or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
eeth	76 234 French	Funeral	725 Spaniards N	eck Road 2. Was Decedent Ever in U.S	13.	21617 Was Decedent of Hi		(Specify Yes or No-	USA 14. Race - Ame	ncan Indian,
ē	ar Itan	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes & ☐ No If Yes, Give	1	f Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)	Black, White	e, etc.
215-0036 thin 72 hours after	Exe	d by	3ÆWidowed 4 □ Divorced	Year or Dates:		X	Specify:		Specify:	hite
5-0	"netu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of v	vorking	16b. Kind of Business/	Industry
₹ ₹	then re M	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		gisterec		2	Health	Care
10 Z	ital Hygiene. Id other then "natural", or itame 23a or 28a-1 show event, tra Madical Examinar mast be notified at	Be Co	17. Father's Name (First, Middle, Last)		I/C	JIS CELEC		lame (First, Middle,		reure
ylan ould be	Venta irked itic ev	To 8	Edward Gerhard	Hettinger			Clara	Elizabe	th O'Brie	en
Maryland d 2 should be file	le mand		19a. Informant's Name/Relationship (Typ			*			r, City or Town, State, 2	
	Health em 27 ther to	-	John D. Leekley 20a. Method of Disposition	•		NOTULE E	or abdwa	Date Date	20c. Location - City or	Town State
altimore,	Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic DDCs.		1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	metery, crei	natory or other place			QUEENSTOWN,	5320
ii.	ortan ortan injur		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lisense		22	. Name and Addres	s of Facility			
B g	Depa Impo eny ii	19	Varmas K. S.	elfenten	F3	ELLOWS, HE	LLENRET	N & NEWNA CENTRE	M FUNERAL H VILLE, MD 2	OME, P.A. 21617
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.						Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	Pul	mar	ing t	tupera	tewsic	20	Onset and Death
	Medical aminer		resulting in death)	Due to (or as a conseque	ence of):	1.56	-0	1 00	Λ -	= 10: 10:4
		- G	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):	SYRUCK	EFL	(N COURCE	VISCAS	- loyeris
petn	ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events		,					
760, te be executed	en andrial-tra		resulting in death) Last	Due to (or as a conseque	ence of);					
~~ ~	hysicien and the burial-transit	IIcal	d							
. Box 68 death certifica	igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE:	Bc. If yes, outcome of pregnan						
. Box	attend for us	lan	in the past 12 months?	1 Live birth 2 ☐ Fetal (death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
o. 💈	y the	ysk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		2 01.101 (0,000.1)/				
Records, P.O The law requires that the	ned to	y PI	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ord:	been sig should b		MEVM	roid net	Wi	D7		1 U Y	res 2 10 6 3 □ Pro	obably 4 Unknown
Records,	as be	Completed	1), Abete	3 - Adu	it (Juse t		24a. Whas a autop	sy prior to d	topsy findings available completion of cause of
ت ت	cate h	Cou	Ostropa	Losis				perfor 1 ☐ Yes	med? death? 2 No 1 ☐ Yes	2 No
Vision of Vita Attending Physicien:	certifi rector	Be	25. Was case referred to medical harminer?	ospital:		ot 3Cl DOA Othe		Death (Check only or		
o g	or this aral di	7: To	1 Yes 2 No	28a. Date of Injury	28b. Time o	1 3 DON	4 🗀 I ani Siri		ence 6 Other (Spec	orfy)
ig ig	ath. r: Afte e fun	atio	1 Natural 5 Pending investigation	(Month, Day Year)	Injury		(? ∕es 2 □ No			
	irecto irecto i by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, sti	eet, factory, office		28f. Location (S City or Tow	Street and Number or Ru m, State)	ıral Route Number,
	hours aft unerel Di ty filled in							1		
Hosp	24 hor	edical	29a. Certifier 1 Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examination	rledge, deat on and/or in	n occurred at the time vestigation, in my of	e, date and pla pinion, death oc	ace, and due to the o courred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
Div To the Hospitel or	within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Mec	29b. Signature and title of continu			29c. License	number	- 2	29d. Date signed (Monti	n, Pay, Year)
_	21.0		1///			D00	56076		9/23	104
10	11/11		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print)		<u>-</u>		1
10	CC		PATRICIA A. BOWY	YER, M.D., 130		POINT RO	AD, STE	VENSVILLE	, MD 21666	
		te	ST. Date med (Month Com)	004 September 5 Signatu	110					

		For	State of Marylar				•	_	
		1 - State Registrer		Cei	tificate of I	Death		eg. No.	32844
Physic		1. Decedent's Name (First, Middle, Last) LEO LAGANA					2. Date of Deat Month SEPT	Day Year	3. Time of Death 4 11:51 A ^M
/Med Exam		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of Death	DHII .	4c. County of Dea	
		SHADY GROVE ADV			ROCK			MONTGO	
Funera		5. Social Security Number 6. Sex 17	M 2□F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Bii	rthplace (State or Foreign ountry)
Director		Usual Residence of Decedent					JUNE 19	9 1915 W	ASH., DC
aryian show	_	10a. State 10b. County MONTGOM		ty, Town or Lo OOLES\					10d. Inside City Limits 1 Yes 2 No
death with the Maryland ims 23e or 28e-f show if its the facilities at	recto	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What C	
th with 23e or	ai Di	19608 GOTT STRE	ET		20837	7		USA	,
er dea	uner		2. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
ING 21215-UU36 be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or Items 23e or 28e-f show event, the Mexical Exercitmen reast be motified at	Completed by Funeral Director	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1□Yes 2 No	Specify:		Specify: W]	HITE
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other then "nature!, or treumatic event, the Mexical Exert	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup- kind of work done of	during most of work.	ing	16b. Kind of Business	/Industry
within sene.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired FSEEING	•		π ΛΙΙ D Τ Cπ	INDUSTRY
d 2 filled I Hygi other	Be Co	17. Father's Name (First, Middle, Last)		DIGIT.	ISEEING	18. Mother's Name	e (First, Middle, M		INDUSTRI
	TO B	ANTONIO LAGANA				ANGELA	FORAME		
re, Maryl2 s 1 and 2 should i Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type TONY LAGANA / S	oe, Print)		-			City or Town, State,	
ther ther		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of			20c. Location - City or	
Pages Nent of Int: If i		1 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State CE	cemetery, cren DAR H	natory or other place LL CEME	T. 10/2	/04	SUITLAND	, MD
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe once.		21. Signature of Funeral Service License	е		Name and Addres	ss of Facility	HOME		
		220 Rout 1 Enter the disease or compli	actions that agused the dea	F	P.O. BOX	C 86. BA	RNESVII	LE, MD	20838 Approximate
Physician	ı	23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final					or respiratory arre	;5l,	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	CORONARY Due to (or as a consec		RY DISEA	ASE			MONTHS
Examiner		Sequentially list conditions, b	. Due to (or as a consec						
ited insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- Due to (or as a consec	quence or):					
60, be executed sician and burial-transit		that initiated events cresulting in death) Last	Due to (or as a consec	quence of):					
	dicai								
BOX 68/t Jeath certificate be attending physic	/Me	IF FEMALE:	3c. If yes, outcome of pregn	ancy				23d. Date of de	liven
. 0 9 9	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)			Month	Day Year
Hecords, P.O. The law requires that the de the has been signed by the a	Phys	9 🗆 Unknown	9□ Unknown						
ds, signed d be d	d by	Part II. Dther significant conditions con NON HODGKINS	•	sulting in the ur	nderlying cause give	en in Part I.		accouse contribute to s 2 🛣 No 3 🗆 P:	o the cause of death?
Kecords, he law requires t e has been signe	iete						24a. Was an		utopsy findings available
The lay	Completed						autopsy	prior to death?	completion of cause of
	BeC	25. Was case referred to medical examiner?				26. Place of Death	1 Yes 2 1 (Check only one	·	2 10
Thys this al di	2	1 ☐ Yes 2 No		ER/Outpatien		4 Nuising Ho		nce 6 Other (Spe	city)
_ _ _ _ _ _ _	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	yat k? Yes 2 □ No	28d. Describe hor	w injury occurred	
DIVISION of or Attending efter death. Director: After d in by the fune	tifica	3 Suicide 6 Could not be	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre			28f. Location (Str. City or Town,	eet and Number or Ri	ural Route Number,
urs efte			M						
DIVI: To the Hospitel or Att within 24 hours effer d To the Funerel Direct completely filled in by	Medicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best of my known to the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my of	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	s stated. a to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier			29c. License		29	d. Date signed (Mont	h, Day, Year)
		I Chilie yege	e/ RAJA COI			52	S	EPT. 30,	2004
5		30. Name and address of person who co CHITRA RAJAGOP	mpleted cause of death (Item AL , MD 1811			T.TD DD	OT 21777	MD 200	2.2
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	A /	TIL DK.	OFNEX	, MD 208	34
Regie	100	00T 0 A	2004 \ /zener	-	11 /10	n. 11 1			

				Please	Type or Pri	nt in Black In	delible Ink.	Ensure All	Copies	Are Legil	ble.	
			For State		State of M	aryland / Depa	artment of H			200	11.	2201.5
	الدورين		State Registrar 1. Decedent's Nam	e (First, Middle, La	ist)	Ce	runcate or i	Dealli	2. Date of Dea	Reg. No. U	14	3. Time of Death
	Physicia		Agnes		Marie	McDona	ld	14	Month	Day	Year	0757 AM
	/Medic Examin		4a. Facility Name (If not institution, giv	ve street and number,			r Location of Death	70,011	4c. County		0.01
					ospice Unit		Baltimor			n/a		
	Funeral Director		5. Social Security N 219-03-8	8536	· Clu office	ge (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Pay Nov 13	, 1917	9. Birthplac	ce (State or Foreign
	Maryland -f show	tor	Usual Residence of 10a. State MD	10b. County Allega	ny	10c. City, Town or Lo	perland				100	d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than "natural", or items and be multified at	Funeral Director	10e. Street and Nu. 10 N. Lil		et Apt. 514	-I	10f. Zip Code	21502		10g. Citizen of W		/ ?
	death	ner	11. Marital Status		12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race	e - American	
36	s after , or ite	y Fu	1 ☐ Never Marr 3 ☑ Widowed	ried 2 Married	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 □ Yes 2 No	Specify:		1	white	
9	72 hours "natural", adical Ext	Completed by		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu		
215	thin 72 ho e. an "natur Madical	plet	(Spec	cify only highest gr ondary (0-12)	ade completed) College (1-4or	5+)		during most of working)	1			
21	be filed withintal Hygiene. Ind other than			12		homer	naker	40 Marka ta Mana		own hom		
and	ed la la la la la la la la la la la la la	Be	17. Father's Name	T. Kerns	t)			18. Mother's Name Deanie				
Ž	2 should be and Mental is marked of aumatic eve	ို	•	ame/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	I Route Numbe			ode) -
Ma	nd 2 ilith a 27 is r trai		Joyce D	ignan	daug	hter 206	Wills Cree	ek Avenue	Cumb	erland	MD	21502
Baltimore, Maryland 21215-0036	o				□Removal from State	20b. Place of Disportant Competery, creed Forest Glen	matory or other place	ce)	ate 10/1/2004	Green S		
Balti	permit. Pag Department Important: I any injury o		21. Signature > Fu	uneral Service Lice	insee	re lli 2		is er Facility Funeral Hol Jinia Avenue:		and MD 3	21502	
			23a. Part1. Enter t	the disease, or con	nplications that cause	d the death. Do not en					A	Approximate nterval Between
4	Pnysician		Immediate Cause disease or condition	(Final	3	broast	- cmce	Γ			C	Onset and Death
	/Medical Examiner		resulting in death)	(Due to (or as	a consequence of):						
	_xammor	<u>.</u>	Sequentially list co	onditions,	b	a consequence of):					_	
	uted d ansit	Examiner	cause. Enter Under Cause (Disease or that initiated event	erlying r injury	`						-4	
60,	be executed ician and burial-transit		resulting in death)	Last	Due to (or as	a consequence of):						
6876	ate be hysici the bu	lical		•	d							
.O. Box 6	The law requires that the death certificate b tale has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	2 months? □No		2 ☐ Fetal death 3	□Ectopic pregnancy	1		23d. Date Mor	e of delivery oth Da	r ay Year
Δ.	uires that the signed by ald be detacted		Part II. Other signi	ificant conditions	contributing to death	but not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contr		cause of death?
of Vital Records,	he law requir e has been si age 2 should	Completed by							24a. Was a autop perfor	sy p med? d	Vere autops prior to comp leath?	y findings available pletion of cause of
ital		Bec	25. Was case refe examiner?	rred to medical				26. Place of Death		· · · · · · · · · · · · · · · · · · ·		
× ×	Physician: this certificanal director,	ဂ္	1 ☐ Yes 2 ☑		Hospital: 1 ☐ Inpat			1 110101119 11011				hospice
o uc	ling P	on:	27. Manner of Dea 1 Natural	5 Pending	28a. Date of Inj (Month, D	ury 28b. Time o ay Year) Injury	Wor	yat k? Yes 2 ∐No	28d. Describe h	ow injury occurre	be	
Division	or Attendin after death. Director: Af in by the fur	Certification;	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not determined	be 28e. Place of Ir	ijury - At home, farm, st tc. <i>(Specify)</i>			28f. Location (S City or Tow	Street and Numbern, State)	er or Rural F	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co	29a. Certifier (Check only one)	1 Certifying P	hysician: To the besuminer: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the dead at the time, o	cause(s) and mar	nner as state	ed. ne cause(s)
}	To the within To the comple	Me	29b. Signature and	d title of certifier			29c. Licens	e number	2	29d. Date signed	(Month, Da	iy, Year)
	10		30. Name and add	Iress of person		death (Item 23a) (Type	Print)	0007		112	1200	
	4		DAV		SEBERG	30) ST.	Paul Pl	Baltin	nore	MD	212	02
	Sta		31. Date filed (Mor		2	trar's Signature	Sports					
Di	Registi	-	- 0	CT 1 5 20	U4 Depa	we g	Sporks			1.00		

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	Certificate of	Death	R	eg. No. 1	3281.6		
	Physicia	n	Decedent's Neme (First, Middle, Last) TOM: A MACONI TOM: A	710		2. Dete of Deet October		3. Time of Death		
J	/Medic		TOM A. MASON		4b. City, Town, or Lo		4c. County of E			
4	Examin	er	4a Fecility Neme (If not institution, give street end number) Brookfield Manor Resident Care		Middlebu		Carro			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. les	t birthday) If Under 1 Year				Birthplace (State or Foreign Country)		
	Director		219-10-5219 [™] 2□ F 82	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Dey, Feb. 11,	1922 V:	irginia		
	and tand		Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, 7	Town or Location				10d. Inside City Limits		
	Mary	ţ	Maryland Harford	Joppa				1 ☐ Yes 2 ☐ No		
	or 284	ig	10e. Street end Number	10f. Zip Code 210	0.5	1	0g. Citizen of Wha	t Country?		
	ath w	rai	830 West Ring Factory Road				USA	1-1-1-1		
36	within 72 hours efter death with the Maryland ene. than "naturel", or items 23s or 28s-f show in Medical Examiner mast be notified at	by Funeral Director	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Detes: WWII	13. Was Decedent of H If Yes, specify Cub: 1 □ Yes 2 No		cify Yes or No- Rican, etc.)		American Indien, Vhite, etc. White		
9	2 hou	ğ	15. Decedent's Education	16e. Decedent's Usual Occup	pation		16b. Kind of Busine	ess/Industry		
21215-0036	ithin 7	Completed by	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d)	ng .	Constri	saki an		
72	tygier ther th		17. Father's Name (First, Middle, Last)	Painter	18. Mother's Name	(First Middle A		ucción		
lanc	hould be filed within a Mental Hygiene. marked other than matic event, tre M	To Be	Thomas Andrew Maso	on			Gilliam			
Maryland	and 2 should I selth end Meni n 27 ia marke er treumatic			19b. Mailing Address <i>(Street</i> 830 West Ring						
Baltimore,	permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Heelth end Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other treumetic event, it a Medical Examiner must be notified at pine.		20a. Method of Disposition X☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	e of Disposition (Neme of etery, cremetory or other pla ity Lutheran (ce) Cemetery 1	Date 0/11/04	20c. Location - City Taneytov	or Town, State wn, MD 21787		
Balt	permit. Depertrimports any inje		21. Signature of Funeral Service Licenses John M. Stilles M00534		Skiles Funeral Home St., Taneytown, MD 21787					
			23a. Pertit/Enter the diseese, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dyir	ng, such as cardiac o	r respiretory erre	est,	Approximete Interval Between		
-	Physician /Medical		Immediate Ceuse (Final					Onset end Death		
	Examiner		disease or condition resulting in death) a. Chronic Ren			1 month				
	n =	ner	Hypertension		a consequence of): L					
	rificata be axecuted ng physician and es the burial-transit	Examiner	b	s a consequence of):						
60,	be ay	層	Sequentially list conditions, if eny, leading to immediate ceuses. Enter Underlying Cause (Disease or Injury that initieted events.							
68760,	ificata g phys	edicai	resulting in death) Lest	s a consequence of):						
Box	eath cert attendin I for use	M/Ja	d					i		
	e deat he att	Physician/	Part II. Other eignificant conditions contributing to deeth but not resulting	ng in the underlying cause giv	ven in Part I.	23b. Did to	bacco use contrib	oute to the cause of death?		
P.0	that the	E	Congestive Heart Failure			1 🗆 Ye	00 2□No 3□	Probably 45 Unknown		
of Vital Records,	requir been s should	Completed by				24a. Was at perform		4b. Were autopsy findings available prior to completion of cause of death?		
Re	he law e has aga 2	E O				1 D Ye	e 21 X No	1 ☐ Yes 2 No		
ta	i cian ; The cartificate rector, pag	Be .	25. Was case referred to medical		26. Place of Death					
>	Physician; this cartific ral director,	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER		ner: 4 🗆 Nursing Hor	ne 5 🗆 Reside	nce 6 Other (S	Specify) Assisted		
n C	ing Pl		1 Natural 5 ☐ Pending (Month, Dey Year)	Bb. Time of 28c. Injury Wor 1 □	ry et 2 rk? Yes 2 □ No	28d. Describe ho	w injury occurred			
Division	To the Hospital or Attending Physician; The I within 24 hours efter deeth. To the Funers Director: Aftar this cartificate his completaly filled in by the funeral director, page	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of injury - At home building, efc. (Specify)			28f. Location (St. City or Town		r Rural Route Number,		
	pital o	ဦ	29a. Certifier 1X Certifying Physician: To the best of my knowle	dae deeth occurred at the tir	mo date and place a	and due to the or	ouco(c) and manno	r as stated		
	n 24 hi	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my o	ppinion, death occurre	ed et the time, da	ate and place, and	due to the cause(s)		
	To the To the comp		29b. Signature end title of certifier	29c. Licens		25	9d. Date signed (M			
) C) W L Arc	D 4	3643		10/8	3/04		
1	5+1		30. Name end eddress of person who completed ceuse of deeth (Item 2:							
		0	Jason A. Tate, M.D. 1 King: 31. Dete filed (Month, Dey, Year) 32. Registrer's Signatur.	s Drive, Tane		21787				
	Stat Registra		OCT 1 5 2004 Beau	5 Sporks	,					

DHMH 16 Rev 6/95

ORIGINAL

			1- State of Maryland / Dep	partment of Health and Mertificate of Death	, ,	2001	00017
			Registrar 1. Decedent's Name (First, Middle, Last)	ranoate of Death	Reg. 2. Date of Death		3. Time of Death
	Physici /Medic		HARRY THOMAS MUSGROVE		SEPTEMBER	Pay Year 2004	12:20 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		LAYHILL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	SILVER SPRING of If Under 1 Year If Under 24 Hrs.	8. Date of Birth	MONTGOM!	
	Director		215 52 8748 1 [™] M 2□ F 55 Yrs.	Months Days Hours Min.	July 20	1949 Ma	place (State or Foreign ntry) aryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mary a-f sho	tor	Md. Montgomery Brooke	ville			1 ☐ Yes 2 No
	or 28e	Oirec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	sath w	erai l	22200 New Hampshire Avenue	20833		United Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28e-f show morphant: If item 27 is marked other than "natural", or itams 23a or 28e-f show any joilury og other traumatic event, it is Modical Examinant be notified at annes.	by Funeral Director	11. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	can Indian, etc. N ite
2-0	72 hou	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16b	o. Kind of Business/In	dustry
21215-0036	within ane. than "	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Co	
	Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last)	dia Specialist 18. Mother's Name	e (First, Middle, Maid	County Sch den Sumame)	10015
/Jan	Mental Mental arked	To B	Harry Z. Musgrove	Inez	Thomas		
Maryland	l 2 sho			ling Address (Street and Number or Rura			,
	Healfler 2		20a. Method of Disposition 20b. Place of Disp	OO New Hampshire Av		Keville, M Location - City or To	
altimore,	Pages Int. E. E. E. E. E. E. E. E. E. E. E. E. E.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) **Commetery, critical from State Metropol	ematory or other place) litan Crem. 9/29		Alexandria	
Balt	permif. Departr Importa any inju		21. Signature of Funeral Service Licensee Murue J. W. Barcher	Muriel H. Barber P. O. Box 5038,	Funeral H	lome	20882
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
	Prr <u>ysician</u> /Medical		Immediate Cause (Final disease or condition resulting in death)	cardiac d	leath		Onset and Death
	Examiner		Due to (or as a consequence of):				
ě.		ner	Sequentially list conditions, if any, leading to immediate				
	ecufer and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	icafe be execufed physician and s the burial-transif	dical E	bue to (or as a consequence of).				
9	tificafe ig phy: as the	ledic	0.				
. Box	death certific e attending p id for use as	Physician/Me	1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
О. О	that the de led by the a defached t	Phys	9 Unknown 9 Unknown				
Records,	The law requires that the death certifi te has been signed by the attending i age 2 should be defached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobacc	2 No 3 Prob	
Šeč	has by	Completed	Cerebrovancular d	esease	24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
-			25. Was dase referred to medical	(disease	1 □ Yes 2 🔀		2□ No
آهُ <	nysicia lis cert direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death		6 ☐Other (Specifi	<i>(</i>)
0	Attanding Physician: The r death. sector: Affer this certificate h. ector: Affer this certificate h. y the funeral director, page		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how in		
Sion Sion	or Attand after death Director: in by the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	M 1 Yes 2 No	28f. Location (Street	and Number or Rura	l Route Number
لجَوَ		Certification;	4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, St.	ate)	
234°C	Hos Func	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, dea 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a ivestigation, in my opinion, death occurred	and due to the cause ed at the time, date a	o(s) and manner as st and place, and due to	ated. the cause(s)
R	To the within 2 To the complex	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	Day, Year)
-	5		30. Name and address of person who completed cause of death (Item 23a) (Type	D S S Z O Z	54	ept 29,3	2004
	Fee			D38262 Print) Lesearch BLVD	Rock	ville ma	20850
	Sta Registr		SEP 3 0 2004 32. Registrar's Signature	Sparks			

	4-6180		332232	Please T	ype or Pri										.	
D	OS		For State Registrar		State of M	aryland				lealth a <i>Death</i>	ind Me		giene Reg. No			201.0
	Physici /Medi		1. Decedent's Name (Fi		teve	Mon	ıterı	oza				2. Date of De Month Septem	Da			3. Time of Death 0117 a M
	Examir		4a. Facility Name (If not West Willa		street and number)					r Location of		эерга.	40	County of D	eath	011/ d
	Funeral Director		5. Social Security Numb 219-11-94		7. Ag	ge (in yrs. last	t birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	24 Hrs. 8 Min.	B. Date of Bir (Month, Da	iy, Year,	9. 35 N	Birthplac Country	ee (State or Foreign) Vland
	Maryland f show	jo.		cedent b. County Montgom	ery	10c. City, T	Town or Lo									. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 28a st be notifi	ai Director	10e. Street and Number 25957 I		e Court				p Code 2087	72				Og. Citizen of What Country?		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show amportant: if Item 27 is marked other than "natural", or Items 23s or 28s-f show amportant: if Item 27 is marked other traumatic event, the Marical Existificat must be natified at once.	by Funerai	11. Marital Status 1 ऒ Never Married 3 ☐ Widowed 4 ☐	12. Was Decedent Armed Forces? 1 Tes 2 If Yes, Give Year or Dates:			Was Dece f Yes, spe		Specify:		ify Yes or No ican, etc.)	Specify:				
1215-0	vithin 72 ho ne. han "natur e Madical I	Completed	15. (Specify o Elementary/Secondar	Decedent's Educ only highest grade ry (0-12)	cation completed) College (1-4or t			kind of w DO NOT i	ork done o use retired					and of Busine	ss/Indus	
Maryland 21215-0036	id be filed v ental Hygie ked other t ic event, ID	To Be Co	17. Father's Name (First Raul E.		roza		Student 18. Mother's Name (First, Middle Jesus E. Jand							Coll Sumame)	ege	
	and 2 shousalth and M	-	19a. Informant's Name/ Jesus E.			c	19b. Mailin 259	ng Addres	Address (Street and Number or Rural Route Number, 57 LaSalle Court Dama					or Town, State	e, Zip Co 208	972
altimore,	tment of He tant: If Iten				cemi	etery, cren	position (Name of rematory or other place) of Heaven 10/01/04					Sil		pri	ng,Md	
Ba	permit Depar Impor any in		21. Signatur of me al Service Iconsee 22. Signatur of me al Service Iconsee PHILIP D. RINALDI FUNER 9241 Columbia Blvd. Sil 23a. Parli. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line.									ver	SERVI Spri	ng,	Md20910 oproximate terval Between	
	Physician /Medical Examiner		Immediate Cause (Fina disease or condition resulting in death)	al Ca	Due to (or as	Mult a consequen		inj	mie)					Or	nset and Death
,160,	ite be executed iysicien and ne burial-transit	icai Examiner	Sequentially list condition of any, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	C	Due to (or as		<i>'</i>									
P.O. Box 68	The law requires that the death certificate to the law requires that the assembly signed by the attending physic age 2 should be detached for use as the band.	Physician/Medic	IF FEMALE: 23b. Was decedent pre- in the past 12 mon 1 □ Yes 2 □ No 9 □ Unknown	nths?	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3	Ectopic p	pregnancy					23d. Date of a	delivery Da	y Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significan	t conditions con	tributing to death b	ut not resultin	ng in the ur	nderlying	cause give	en in Part I.		23e. Did to				eause of death?
Vital Records,		Completed	95 War and a standard									1 Yes	rmed? 2 \(\text{No}	prior t death	o comple?	findings available etion of cause of
Division of Vit	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	ation; To Be	2 🕅 Accident	Pending investigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da)	ry y Year) 28	Outpatient b. Time of Injury	-	28c. Injury Wari	er: 4□ Nurs	sing Home	d. Describe t	dence now injui		njoh	struck
DIVIS	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Certification;	4 Homicide	Could not be determined	28e. Place of Injuding, et	c. (Specify)	Ro	ad			Po	f. Location (S City or Tox	reet an vn, State	d Number or West mD	Rural Ro	land Road
	the Hosp hin 24 hor the Fune npletely fi	Medical	one)	Medical Examin	ician: To the best er: On the basis of and manner sta	examination	dge, death and/or inv	estigation	n, in my op	oinion, death	place, an	at the time,	date and	d place, and d	ue to the	e cause(s)
)	3	-	29b. Signature and title	hi. n	d. n			C	c. License	number				te signed (Mo tember		*
			30. Name and address of	LI, m	(1)				11 P€	nn St	reet,	Balt:	imor	e, Mar	ylan	d 21201
	Sta Registr		31. Date filed (Month, D.	30 200	P -	ar's Signature معمر	B	Spo	aks	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 22:53 p Vivian Merritt Sept. 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cheverly Prince George Prince George's Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 ☐ M 2 💆 F 71 4, 1932 N. Carolina Director 245-62-9670 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 SyYes 2 □ No Director Prince George Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 238 20774 1077 Largo Rd #514 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian natural, or itame 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Nursing Home Care Provider 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lillian Carr Jesse E. Bass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14500 Medwick Rd, Upper Marlboro, MD 20774 Nathan Merritt/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10/2/04 permit. Page Depertment of Important: if any Injury or once. Lincoln Memorial Suitland, MD 22. Name and Address of Facility Strickland Funeral Services Funeral Service Litenses 21. Signatuta at 6500 Allentown Rd, Camp Springs, MD 20748 n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sinck, or hearl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Physician /Medical Due to (or as a consequence of): **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Hypertension and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Deep vein thrombosis of right femoral vein Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detact 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 P/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No neref Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 148152 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel Semegn 1221 Merchantile Ln, Largo, MD 20785 31. Date filed (Month, Day, Year) 2. Registrar's Signature State OCT 0 4 2004 Registrar

			1 - For State Registrar	State of Marylar	nd / Depa		lealth and M	lental Hygi	-	. 32951				
	Physici /Medie		Decedent's Name (First, Middle, Las Mary	L.	N	Mundell		2. Date of Death Month 09/29		3. Time of Death 4:00 P M				
	Examir		4a. Facility Name (If not institution, give Southern Maryla			4b. City, Town, o	r Location of Death		4c. County of Prince (Death George's				
	Funeral Director			7. Age (In yrs. ☐ M 2/□XF 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 02/08/1	918 °	Birthplace (State or Foreign Country) Ohio				
	the Maryland 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		ity, Town or Lo Distric	cation t Height	s			10d. Inside City Limits 1 ☐ Yes ŽŽŠNo				
<u> </u>	ath with the 23a or 28a unt be not	al Direc	10e. Street and Number 7111 Mason Stree	t		10f. Zip Code 2074	7	10	g. Citizen of Wha	at Country?				
19-04 4:00 fm Maryland 21215-0036	or Items	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ②X No If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cuba I ☐ Yes ¾X No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White				
4. 21215-0	d 21215-003 filed within 72 hours Hyglene. other then "naturel;		15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. L Popula	lent's Usual Occup kind of work done DO NOT use retired LION IEC	ation during most of worki hnician	ng	66. Kind of Busin Federal	Government				
O of	should be filed and Mental Hyges marked other umartic event,	To Be C	17. Father's Name (First, Middle, Last) Leo J. Ritz	ka				(First, Middle, M	o, Maiden Sumame) Ertle					
28-	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then eny injury or other treumatic event, Ite Monee.		Mary C. Boyce / Do	aughter	9400	Grandhav	and Number or Rura en Avenue	Upper Ma	arlboro,	MD. 20772				
$arphi_{\mathcal{A}}$ Baltimore,	t. Pages rtment of I rtent: If ite		20a. Method of Disposition 1878 urial 2 Cremation 3 Removal from State 14 Donation 10 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Resurrection Cem. 20c. Location - City or Town, State 10/04/2004 Clinton, Maryl											
Bal	Depared Important Importan		21. Signature Juneral Service Licens 23a. Page. Enter the disease, of comp shock, or heart failure. List only of	das	6	160 Oxon	ss of George Hill Rd	Oxon H	ill, Mar	l Home PA yland 20745				
68760,	Physician / Medical Examiner whysician and prize	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	quence of): quence or):	Witc	CARDIO	HICUU	A. 013	Onset and Death				
, .O. Box 6	the death certificate y the attending phys ached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year				
Mary ecords, P	w requires that the de: been signed by the a should be detached f	ed by Pi	Part II. Other significant conditions co	ntributing to death but not res		derlying cause give	on in Part I.			te to the cause of death? Probably 4 Unknown				
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sion of Vit	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at 2	(Check only one) ne 5 Resident 8d. Describe how		Specify)				
	oitel or Attures after de oral Directoried in by tilled i	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	y)			City or Town,	State)	r Rural Route Number,				
	the Hosp nin 24 hor the Fune npletely fi	Medical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or invi	estigation, in my op	inion, death occurre	d at the time, date	and place, and	due to the cause(s)				
	viti To	<	29b. Signature and title of certifier			D-1	A			onth, Day, Year) 80 29, 200				
0	R (12)		V. WISOTHY M		QU)	LINE C	EURL	LUAUDO	UF, Lde	en 29,200 d. 2060?				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 29, 2004 **Physician** 1511 Gary Lee McClelland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 23, 1955 Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2 F 49 Illinois Director 268-54-2264 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location. 10d. Inside City Limits show injury or other traumatic event, the Medical Examiner must be notified at Talbot. 17 Yes 2 No Director Trappe 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2924 Ocean Gateway 21673 tетs 23e U.S.A. 12. Was Decedent Ever in U.S. Ampd Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1973–79 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 No <u>ک</u> Specify: white 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 salesman insurance 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill treent of Health and Mental Hitant: If item 27 is marked out 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles H. McClelland Ramona Barbeau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramona McClelland mother 6563 Roselawn Ave., Reynoldsbury, OH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Department of Important: If any injury or once. 10/4/04 * 4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn Columbus, OH 21. Signat of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Tome P.A. he willers 700 Locust St., Cambridge, MD 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Securitize y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. if yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No To the Funerel Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Xes 2 □ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dira 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO44282 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

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Records,

of Vital

Division

KURROWSKI,

31. Date filed (Month, Do real)

M:D 1 2003. Registrar's Signature

44/6 Bachelors PL. Rd. Oxyong MO 21654

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year IZABETH 2255 M /Medical SEPTEMBER 26 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SALISBUM NICOMICO DHIN LIVA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 7 Hours 218-20-4726 Usual Residence of Decedent Director 10-28-16 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant. The Medical Examinar must be notified at 10d. Inside City Limits RISFIELD Director Somerset 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220-SOME death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: 3 Widowed 4 □ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If tem 27 is marked other than "r any injury or other traumatic aucont Elementary/Secondary (0-12) College (1-4or 5+) PICKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDENIND, 21822 20 Cocation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 remation 3 Removal from State 4 ☐ Donation 5 Other (Specify) 21. Signature 2/80/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** congestive Cardionyopathe /Medical Due to (or as a consequence of): Examiner Socientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ó 4☐Pregnant at time of death Month Day 5 Other (specify) the 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No Be Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30853 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene AMEND ITEM# 23a, per dr, QACHOel Widate 401 Beath Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** SEPTEMBER 24, 2004 4:00 AM DONALD CECIL MILLER /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S CHESTER 2856 COX NECK ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**▼**M 2□ F DEC. 11, 1939 VIRGÍNIA 227-48-0677 64 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show must be notified at 1 ☐ Yes 2 X No Directo QUEEN ANNE'S CHESTER MD 10f. Zip Code 10g. Cilizen of Whal Country? 10e. Street and Number or Itame 23a 2856 COX NECK ROAD 21619 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Ie marked other than "natural", or Item any injury or other traumatic event, the Medical Everther. Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ MARINE SURVEYOR 12 MARINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ KENZEL MILLER NELLIE MASON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATRICIA MILLER/WIFE 2856 COX NECK ROAD, CHESTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ¹ 4 ☐ Donation CHESAPEAKE CREMATORY 09/28/2004 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 21. Signature 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER **Physician** years /Medical years Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or many) that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending F for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 Yes 2 No 1 Yes 2010 Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 10 this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury al Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) δ determined 4 Thomicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Da Vear SEPTEMBER 27, 2004

Physician /Medical **Examiner** For State Registra

Funeral Director

death with the Maryland or 28a-f show Examiner must be notified at 'natural', or Items 23a filed within 72 hours after i Hygiene. The Mudical than " other d 2 should be fil h and Mental H; ' is marked oth permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked c any injury or other traumarts

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed burial-tran and the attending physician use as the Jo detached signed by pe o peen page 2 has certificate or Attending Physician: the funeral director, this After after death.

Division of Vital Records, P.O. Box 68760,

Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER 12 17. Father's Name (First, Middle, Last) Be PAULINE MCDONALD FRANCES DILLEHAY 19a. Informant's Name/Relationship (Type, Print) GEORGE A. MALLET/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY | 10/03/2004 4 Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee FILOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in fach line. Immediate Cause (Final disease or condition resulting in death) rces Due to (or as a conseque of): Weumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗆 No Completed 24a. Was an autopsy performed? 2 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 21 No 2 FR/Outpatient 3FT DOA Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury Natural 5 Pending investigation 2 🗌 No 1 Tyes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide telestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 1005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1735 JUNE MARIE MALLET 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ANNAPOLIS ANNE ARUNDET. ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🖫 F Yrs OHTÓ JULY 29, 1923 181-20-1140 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No STEVENSVILLE Directo **OUEEN ANNE'S** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 410 BENTON ROAD USA 21666 14. Race - American Indian, Black, White, etc. WHITE Specify 16b. Kind of Business/Industry ACCOUNTING 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 BENTON ROAD, STEVENSVILLE, MD 20c. Location - City or Town, State STEVENSVILLE, MD

Anna

2004

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ 100

3 Probably

Month

Approximate Interval Between Onset and Death

Year

4 Unknown

State Registrar

completely filled in by

within 24 hours To the Funeral

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To the

DHMH 17 Rev 1/2001

nedica

legistrar's Signature

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2004

Woins

DHMH 17 Rev 1/2001

State

Registrar

and address of person

1 2004

Atricia

31. Date filed (Month, Day, Year)

who completed cause of de-

-ADINON

(Item, 23a) (Type, Print)

KW111 Penn Street, Baltimore, Maryland 21201

			Please	Type or Pri State of M						All Copie Mental H		_	
			1 - State Registrar			Ce	rtificate	of D	Death		Reg. N	Onni	00000
	Dhamini		1. Decedent's Name (First, Middle, Las	t)		_				2. Date of D		time U U III	3. Time of Death
	Physici /Medic		Virginia	Mae	N	orth				SEPT.	26,	^{ay} 2004 Year	7:10 AMM
	Examir		4a. Facility Name (If not institution, give Salisbury Nursing			iter	4b. City, To		Location of De	ry, Md.	1	c. County of Deat	h
	Funeral		Social Security Number 6. Security Number		ge (In yrs	. last birthday		Year	If Under 24 H	rs. 8. Date of B	irth You	9. Birtl	hplace (State or Foreign untry)
C	Director		216-12-1807	□M 2X1F 8	32	Yrs.	MOTHERS	Days	Hours Mi	11/1!	9/19		aryland
pue	302		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or L	ocation						10d. Inside City Limits
Aanyii	t sho	5	_	omico		Salis							1 ⊠Yes 2 □ No
the	288-	ect	10e. Street and Number	JILLO		Dallsi	10f. Zip C	ode.			10a C	itizen of What Co	
with	3a or	0	200 Civic Ave.					2180	0.4		109.0	USA	unay:
death	ms 2	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in l	J.S. 13.				(Specify Yes or Narto Rican, etc.)	0-	14. Race - Ame	rican Indian,
after	or ite	E	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 🔀			1 Yes, specify	_		erto Rican, etc.)		Black, White	
Suc	Era	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates	:		TLITES 225	Z1 NO	Specify:			Specify:	white
d 61613-0030 filed within 72 hours after death with the Maryland	"nati	Completed	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>		16a. Dece (Give	edent's Usual (Occupat done du	tion uring most of w	rorking	16b. I	Kind of Business/I	ndustry
withir	than than	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)		ousewi					ъ	
	Hygi other ant, I		17. Father's Name (First, Middle, Last)			п	Jusewi		18. Mother's N	ame (First, Middl	e. Maide	Dome:	stic
d be	n and Mental Hygiene. 7 is marked other than traumatic event, tra Me	To Be	Peter Linnett							ie Mae		,	
should	s mar	-	19a. Informant's Name/Relationship (7			19b. Maili	ing Address (S	Street ar				or Town, State, Z	ip Code)
and 2	Health a tem 27 that ther tra		Bruce North/sor	1		30 0	Glasto	nbu	ıry Pl	ace, La	igun	a Nigue	el, CA9267
98 1 S	Department of health and Merked the Than "natural", or flems 23a or 28e-f show fingortant; filem 27 is marked other than "natural", or flems 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀	Damaual from State	20b.	Place of Dispo	osition (Name	of er place	2-1	Date	20c. L	ocation - City or 1	Fown, State
Pages	Department Important: I any injury o once.		'4 □Donation 5 □ Other (Specify		' Pa	ark	rotoning the	IOLI	9	/29/04	Sa	lisbury	, MD
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Pin	ysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on a ch	9	ith. Do not en	ter the mode o	of dying,	, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
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flicate	g phy as the	edlo		u.									
The law requires that the death certificate	use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1⊟Live birth			7					23d. Date of deliv	very
deat	e atte	lcla	in the past 12 months?	4□Pregnant a			⊒Ectopic pregi ⊒ Other <i>(speci</i>					Month	Day Year
at the	by the	hys	9 🗆 Unknown	9□ Unknown									
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requir	been si should l	ted								10	Yes 2	□No 3□Pro	bably 4 Onknown
aw C	2 5	Completed								24a. Was	psy	prior to co	opsy findings available ompletion of cause of
	ate pac	Cor								perf	ormed? 2 □ N o	death?	2 No
ician	iis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:						eath (Check only			
Phys	(O) TO	. To	1 Yes 2 No	1 ☐ Inpati		ER/Outpatier 28b. Time o		Other	4 (Tarability			6 Other (Speci	fy)
ding	After thi	tlon	1 Matural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	M 200.	. Injury a Work? 1 □ Ye	es 2 🗆 No	28d. Describe	now inju	ry occurred	
Atten	Director: /	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At h	iome, farm, sti				28f. Location	Street ar	nd Number or Run	al Route Number.
al or	d in t	Certification:	4 Homicide	building, e			, , , , , , ,			City or To	wn, State	9)	
To the Hospital or Attending Physician:	To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best iner: On the basis of and manner st	of examina	owledge, deat ation and/or in	h occurred at t vestigation, in	the time my opir	, date and place nion, death occ	e, and due to the curred at the time,	cause(s date an) and manner as s d place, and due t	stated. o the cause(s)
To th	To the I	Me	29b. Signature and title of certified	11)			29c. L	icense r	number	_	29d. Da	te signed (Month,	Day, Year)
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50)		30. Name and address of person who c		death (Ite	т 23а) (Туре,	Print)			/	1	//	
	` ;		WILLIAM ROBINS, M.					200	Civic	Ave.,Sa	lisb	ury, Md.	21804
	Sta Registra		SEP 2 9 20	04 32. Regist	rar's Signi	ature &	Spor	Ks	/				

DHMH 17 Rev 1/2001

		1 = For State Registra MEND#15perFH9 1. Decedent's Name (First, Middle, La	State of Ma	miland / Dan		Health and I	Mental Hygi	ODAL	2225
Phys	cian	and the same of th		<u></u>	- ancate of	Dealli	2. Date of Death Month	Day Year	3. Time of Death
/Me Exan Funera Directo	al	4a. Facility Name (If not institution, given the second of	peneral Hos	Spital (Ih yrs. last birthday, 86 Yrs.	01	or Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 3,	4c. County of Death Mont	
- D		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation		1141011 3,	. 1310	10d. fnside City Limits
the Mar r 28a-f st rotified	rector	Md. Montgom 10e. Street and Number	ery	Brookey	7ille 10f. Zip Code		100	g. Citizen of What Cou	1 ☐ Yes 2 ॡ No untry?
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall hygiene. od othar than "natural", or Itama 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	19109 Georgia Av 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	e. 12. Was Decedent E Armed Forces? 1	ver in U.S. 13.		0833 Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - Amer Black, White Specify: W	ican Indian,
21215-0036 ad within 72 hours aff giene. ar than "natural", or than Medical Exami	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	-) (Give	edent's Usual Occup a kind of work done DO NOT use retire Teacher	during most of work	king	Stone Rid	ndustry
Maryland 2 nd 2 should be filed it and Mental Hygis 27 is marked othar traumatic evant, it	To Be C	17. Father's Name (First, Middle, Last, Axel Tulane 19a. Informant's Name/Relationship (Marie	Larson		
		George Evans O'Ke			Bradley	Blvd. Bet	hesda, Ma	$rac{1}{2} rac{1}{2$	814
Itim rit. Pag artment ortant: I	Q	1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	X)	Gate of H	leaven Cer	n. 20	ber 1, 04 S Vol Funer	ilver Spri	ng, Md.
	Sally Control	23a. Part1. Enter the disease, or com	plications that caused t	2	222 Wisc.	Ave., N	.W. Wash.	D.C. 2000	Approximate
SY60, Cate be executed Examine physician and physician and the burial-fransit	ŧ.	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ren. Due to (or as a b. Due to (or as a).	hre				Interval Between Onset and Death 2 inverks
. Box to death certiff death certified attending and for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetaf death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of defive Month	ery Day Year
	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	inderlying cause giv	en in Part I.		cco use contribute to to	he cause of death?
The The page	Completed						24a. Was an autopsy performed	d? prior to co death?	opsy findings available impletion of cause of
Ing Phys	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	2 ER/Outpatier 28b. Time o Injury	f 28c, Injur Wor	er: 4 □ Nursing Ho y at	me 5 Residence 28d. Describe how	e 6 Other (Specifing injury occurred	5y)
i giệc 🧸	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medicaf Exer	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the caus red at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
Withi	W	29b. Signature and title of certifier	Mays, M.	Δ.	29c. Licenso	793	Se	Date signed (Month, ptember 2	19,2004
		30. Name and address of person who all the state phis I. Ma	completed cause of dea	th (Item 23a) (Type,	Print) a Shilip	Daive :	#207 011	nay, mD	20332
S Regis	tate trar	31. Date filed (Month, Day, Year) SEP 3 0 20	32. Registrar	s Signature	Spark	2			

			1 - For Amend It	State of Mems 28a,b,c,	Marylan e per	d / Depa	artment of F	lealth a	and Mental b	Hygien	e 2004	322	60
	0		Decedent's Name (First, Mi		***				2. Date of	of Death		3. Time of	Death
	Physici /Medic		MEDFORD	ODONNELL					Month	59/2	7/200		PW
	Examin		4a. Facility Name (If not institu	ition, give street and number	er)		4b. City, Town, o	r Location o	of Death	40	County of De	ath	
		**************************************	SHOCK TRAUN				Baltim		0411		altimore		
ı	Funeral Director		5. Social Security Number 215–16–3175	6. Sex 1 X M 2 □ F	Age (In yrs. I 85	a <i>st birtnday)</i> Yrs.	If Under 1 Year Months Days	Hours	Min. (Month	if Birth i, <i>Day, Year</i> . 10,) (iirthplace (State of Country) IARYLAND	or Foreign
	ס		Usual Residence of Decedent						DLITE	109	1717 1		
	ahov	ō	MD OUEF	EN ANNE'S		r, Town or Lo SONVII						10d. Inside C	•
	the N	Director	10e, Street and Number	IN ANNE D	GICE	DONVII	10f. Zip Code			10a C	itizen of What		
	h with		4100 MAIN STR	REET			21638			US			
9036	72 hours after death with the Maryland "natural", or Items 23e or 28e-f show offed Examitter and beamilited at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ N 3 ▼ Widowed 4 □ Divord	If Yes, Give	s? □No 194	i3-	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2X No	lispanic Orig an, Mexican Specify:	gin? (Specify Yes o , Puerto Rican, etc.	ir No-	14. Race - American Indian, Black, White, etc. Specify: WHITE		
15-		Completed	(Specify only hig	dent's Education phest grade completed)		(Give	lent's Usual Occup kind of work done OO NOT use retired	durina most	of working	Kind of Busines	ss/industry		
212	d within giene.	Com	Elementary/Secondary (0-12 7	2) College (1-4d	or 5+)	WATER	RMAN			S	EAFOOD		
Maryland 21215-0036	should be filed von Mental Hygie marked other turnatic event, It	To Be (17. Father's Name (First, Midd						r's Name <i>(First, Mi</i> i L LA LILL I				
ary		F	19a. Informant's Name/Relation			19b. Mailin	g Address (Street	and Number	r or Rural Route Ni	umber, City	or Town, State	, Zip Code)	
	C = 01 F		NANCY ALTHOFF	//DAUGHTER				KE DR	IVE, DENT	ON, M	D 2162	9	
Baltimore,	it of t			on 3 Removal from Sta	te C6	ametery, cren	sition (Name of natory or other place		Date		ocation - City o		
Ħ	# ttb.		'4 □ Donation 5 □ Other		STEV				0/01/2004		VENSVII		
Ba	Depa Impo eny il		Kal K	1.70	Lu	FÎ	LLOWS, H 6 SHAMRO	ELFENI CK ROZ	BEIN & NE	WNAM ER, M	FUNERAL D 2161	9HOME, I	P.A.
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate gause. Enter Underlying	a. Due to (or a		ence of):	They , E)	cardiac or respirato	ry arrest,		Approximate Interval Bette Onset and I	ween
68760,	death certificate be executed e attending physician and id for use as the burial-transit	ledical Examine	Cause (Disease of injury that initiated events resulting in death) Last	cDue to (or a	as a consequ	ience of):							
.O. Box	that the death certifice ed by the attending pr detached for use as t	hysiclan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3 [Ectopic pregnancy Other (specify)	,			23d. Date of d Month		/ear
rds, P	w requires that been signed I should be det	by P	Part II. Other significant cond		but not resu	Iting in the ur	nderlying cause give	en in Part I.				to the cause of d	
Vital Records	The law ate has b	e Completed	25. Was case referred to med	ical					a p	1	prior to death?		available ause of
Ž	\$ 5 E	To Be	examiner? 1 Yes 2 No	Hospital: 1 1 Inpa	itient 2∏F	ER/Outpatien	t 3 DOA Othe		of Death Check of sing Home 5 F		6 Other (So	ecify)	
n of			27. Manner of Death 1 Natural 5 ☐ Pen	28a. Date of Ir		28b. Time of Injury	28c. Injury Work	y at		ibe how inju		cony)	
Division	Atten	ertification;	3 Suicide 6 □ Cou	uld not be ermined 28e. Pace of building,		me, farm, stre	1 🗆 'eet, factory, office	Yes – 2 M.	28f. Locatio	on (Street ar Town, State		Rural Route Numb	ber,
	Hos Hos	edical C	29a. Certifier (Check only one) 1 Certifier 2 Medic	fying Physician: To the best cal Examiner: On the basis and manner	of examinati	vledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and pinion, death	place, and due to h occurred at the tir	the cause(s ne, date and) and manner a d place, and du	s stated. se to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of cert	10			29c. License				te signed (Mor		
,			reful	ion who completed cause of			A4417	76435	551403		9/2	7/04	
	5,000		30. Name and address of pers	ion who completed cause of	death (Item	23a) (Type, I	rint)	7	CULTER	v C 1	Division!	OF FL	1
	Sta Registr		31. Date filed (Month, Day, Ye SEP 3	32. High	strar s Signat	ure		NCAL	- 3731c/	· · · ·	<i>y.</i> • • • • • •	J. C.P.	
		1		140		C ACE	The state of the s						

State of Maryland / Department of Health and Mental Hygiene

		Amend Item 25 per me G837 11-16-04Certificate of Death tas Reg. No. 111. 2006
	Physician	1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey Yeer
	/Medical Examiner	Walter Durward Powell September 27,2004 8:45AM 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death
"	Examiner	4100 Twin Arch Road Mt. Airy Carroll
	Funeral Director	5. Social Security Number 219-48-5097 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 56 Yrs. 7. Age (In yrs. last birthday) 56 Yrs. 1 Months Deys Hours Min. 1 Months Deys Hours Min. 1 Month Day, Yeer) Feb. 10, 1948 9. Birthplace (State or Foreign Maryland) 8. Date of Birth (Month, Day, Yeer) Feb. 10, 1948
	dand	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Mary Mary	Md. Carroll Mt. Airy 1□Yes 2□No
	or 28	10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country?
	e 23a	4100 Twin Arch Road 21771 USA
21215-0036	within 72 hours efter death with the Meryland ene. than "natural", or items 23a or 28e-1 show he Medical Examiner must be roctified at empleted by Funeral Director	11. Marital Status 1
5-0	nertu official	15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
12	withir ene.	Elementery/Secondary (0-12) College (1-4or 5+) 2 College (1-4or 5+) Self-employed Contracting
d 2	be filed within 72 ho tel Hygiene. d other than 'natural event, the Medical Be Completed	17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame)
ylar	should be filed want Mentel Hygier marked other than the market event, the To Be Cor	Walter Gustave Powell Margaret Hill
Mar	12 shd h end la me raum	19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Patricia Anne Powell (wife) 4100 Twin Arch Road Mt. Airv Maryland 21771
	es 1 end of Heelth Iltem 27 r other tr	Patricia Anne Powell (wife) 4100 Twin Arch Road Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place) 20b. Place of Disposition (Name of commetery, crematory or other place)
Baltimore, Maryland	permit. Peges 1 and 2 should be filed within Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other than any Injury or other traumetic event, the Matce.	1 Burial 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State Crematory 9/28/04 Alexandria, Virginia Alexandria, Virginia Crematory 9/28/04 Alexandria, Virginia Crematory Proposition Crematory Crematory Proposition Crematory Proposition Crematory Proposition Crematory
alti	permit. Depertmimportal eny infu	21. Signature of Funeral Service Lipensee 22. Name and Address of Facility Old Town Funeral Choices
8	80E 9 8	1205 Belle Haven Road Alexandria, Va. 22307
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) e. V 10 CavCeC
	je je	Due to (or as a consequence of):
	ficete be executed I physicien end st the burial-trensit edical Examiner	U.
68760,	sicien buria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER
	ifficete g phy es the	resulting in death) Lest Due to (or as a consequence of):
Вох	eath cer ettendin Ifor use cian/N	d
	the et ches ches ches the des	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?
P.0	res that the designed by the elbe deteched for by Physical	paralysis of right upper extremity 15 Yes 2 No 3 Probably 4 Unknown
rds	- "O T	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
eco	law requests been 2 shoul	completion of cause of death?
<u>=</u>		1 Yes 2 AND 1 Yes 2 No
Ziti		25. Was case referred to medical examiner? 1 A Yes 1 DOA Cher: 4 Nursing Home 5 Residence 6 Other (Specify)
of	Phys or this erei di	27. Menner of Death 28e. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
io	Attending For death. Sector: After by the funerialitication:	2 Accident investigation M 1 Yes 2 No
Division of Vital Records,	or Atte efter de Directo J in by t	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospital or Attending Physis within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral director and an edical Certification: To	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th withir To th comp	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	10	H58132/MD 9/28/04
	10	30. Name entraddress of person who completed cause of deeth (Item 23e) (Type, Print) Ren Jamin Papai, P.O. 108 C Lisbon (enter Woodbine MD 21797
	State	31. Dete filed (Month, Day, Year) 32. Registrer's Signature
	Registrar	are 01 2001 Sensor B Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** CHARLES ELMER POWELL, SR SEPT 1:43 P M 28, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 806 Maple Avenue Laurel PRINCE GEORGES 7. Age (In yrs. last birthday)

6.5 Yrs.

If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)

Dec. 30, 1938 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F 219-34-7707 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Inforcant: If item 27 is marked other than "neturel", or iteme 23a or 28a-f show any injury or other traumatic avent, the Medical Exactions to notified at one. MD Prince Georges 1X Yes 2 □ No Director Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 Maple Avenue 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black À 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Construction Co 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Thelma Watkins Lee Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Powell, Jr (Son) 806 Maple Ave., Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Remoyal from State MD Nat'l Mem Park 10/5/04 *4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 21. Signature of Funeral Service Compse 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or held failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** Hypertensive Cardiovascular Disease Years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţ in the past 12 months? Year 4☐Pregnant at time of death Month Day 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 5 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate Division of Vital 2X No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check onl. one examiner' Hospital: 1 ☐ Yes 2√2 No Other. 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c, Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only Within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) nay 9/29/04 D23181 200

Registra

2004 01

R.G. Bhujraj,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

704 Gorman Ave., #T1, Laurel, MD 20707

Stephanie Petitt 04-6378

04-637 AKG	'8		1 - For Amend Item Registrar	State of	f Marylar Item 23	nd / Depa a&27 p	artment of GR	Health and N	dental Hygi 04 tas	ene		
	Physici-		Registrar 1. Decedent's Name (First, Midd STEPHANTE	le, Last)	ETITT		uncate or	Deam	2. Date of Death Month October	Day	Year 004	3. Time of Death
0	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town,	or Location of Death		4c. Count		1000 71
			Peninsula Regi	onal Medic	cal Cen	ter	Salisb			Wica	nico	
7.	Funeral Director		5. Social Security Number 212–72–0482	6. Sex 1 □ M 2 💆 F	7. Age (In yrs.	45 Yrs.	If Under 1 Year Months Days		8. Date of Birth 9/15/19	(ear)	9. Birth Cou New	pplace (State or Foreign unity) York
	land		Usual Residence of Decedent 10a. State 10b. County	,	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Mary -1 sh	ţō	MD Worces	ster	Poo	comoke	City					1 ☐ Yes 2 🛣 No
	or 28e	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Cou	intry?
	23a c		3362 Sheephouse	e Road			21851			US	SA	
	tems	Funeral	11. Marital Status	Armed Fo		I.S. 13.	Was Decedent of f Yes, specify Cut	Hispanic Origin? (Sp can, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Amer	ican Indian, , etc.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28e-f show eumatic event, I'm Medical Exartinarinat be rediffed at	by Fi	1 ☐ Never Married 2 🛣 Ma. 3 ☐ Widowed 4 ☐ Divorce	If Yes Giv	re .		1 □ Yes 2 <mark>1</mark> No	Specify:		Specia	fy: turb	ite
9	2 hou	ted t	15. Decede	nt's Education		16a. Dece	dent's Usual Occu	pation		3b. Kind of E		
215	hin 73	pie	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1	-4or 5+)	(Give	kind of work done DO NOT use retire	i during most of work ad)	ring			•
21	ygien /gien ier th	Completed	12	4		Mana	gement		1	Market	ing	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle						e (First, Middle, Ma		,	
<u> </u>	d Mer narke	٩	Francis Joseph 19a, Informant's Name/Relation			105 14-15	- 444 (0)	1	e Marie A			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla F Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, I'm Medical Exertities Instituted at		Edward L. Petit		d)			t and Number or Run Pocomoke				p Code)
	Heal Heal tem 2		20a. Method of Disposition	(1100000	20b. I	Place of Dispo	sition (Name of			c. Location		own, State
e e	Pages ent of nt: If i		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (State	-	natory or other pla	ian Cemetery	8, 2004 ²⁰	Pocomo	oke C	ity, MD
3altimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		21. Signature of Funeral Service		1.10			erson Fun		e. P.A	١	
<u> </u>	Pe m m co		Milled	ADea	in		_	Ave., Po		•		851
8760,	Physician /Medical Examiner building the prival-transit the prival-transit	dicai Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Anaph Due to (ylaxis or as a consec	quence of):	er are mode or cyr	ng, such as cardiac	or respiratory arres	4.		Approximate 1 Interval Between Onset and Death
Box 6	ie death certifi the attending hed for use as	by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ves 2 No		irth 2∏Feta ant at time of c	al death 3	Ectopic pregnand Other (specify)	y			ate of deliv	ery Day Year
rds, F	w requires that the been signed by should be detac	ed by P	Part II. Other significant conditi	ons contributing to de	eath but not res	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba 1 ☐ Yes	1/		the cause of death?
ဝင္ထ	aw requisite been 2 should	Completed							24a. Was an	24b.	Were auto	opsy findings available ompletion of cause of
Ä	The lay ate has page 2	mo:							autopsy performe Yes 2	id?	death?	2□ No
/ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?						h Check onl one			
of V	Physic this co	٩	1 X Yes 2 ☐ No			ER/Outpatien			me 5 Residen	ce 6 □Oth	ner (Speci	fy)
n C	ling F	ion:	27. Manner of Death 1 Natural 5 Pendi		of Injury h, Day Year)	28b. Time of Injury	Wo		28d. Describe how	injury occur	red	
Division of Vital Records, P.O.	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide detern	igation not be nined 28e. Płace buildir	of Injury - At h ng, etc. (Speci	ome, farm, str fy)	eet, factory, office]Yes 2□No	28f. Location (Stre City or Town,	et and Numb State)	per or Run	al Route Number,
	he Hospit in 24 hour he Funera pletely filla	Medical	29a. Certifier 1 ☐ Certifyi (Check only one) 2 ☐ Medical	ng Physician: To the Examiner: On the ba and mann	asis of examina	owledge, death ation and/or inv	occurred at the ti restigation, in my	me, date and place, opinion, death occurr	and due to the cau red at the time, date	se(s) and ma and place,	anner as s and due t	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certific	7 0			29c. Licens	se number	290	. Date signe	d (Month,	Day, Year)
			Molyme	ine Inill	LIM	den		M.E.	(Octobe	er 3,	2004
			\ A (A - A	who completed caus		n 23a) (Type,	•	Ctonct	Dol+4	. M=	~_7	3 21201
	Sta	to.	31. Date filed (Month, Day, Year		Sistrar's Signa	ature		Street,	DOTITION	e, Mar	утап	u 21201
	Sta Registr				Carios	1. A	parte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30, **Physician** Month Year 2004 Kathryn Mae Patrick 0129 September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Jan. 23,1924 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Yrs. Pennsylvania 80 Director 192-12-5525 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or othar treumatic event, the Medical Exaction at Le motifical Exactions. 1 ☐ Yes 2 X No Maryland Cecil Port Deposit Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Cedar Drive 21904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aberdeen Proving Ground Elementary/Secondary (0-12) Twelve Years College (1-4or 5+) Aberdeen, Maryland Dining Hall Assistant Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifford Anderson Margaret Scoffield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth P. Patrick (son) 231 Justice Way, Elkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State West Nottingham Cemetery 10/02/04 Colora, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Costery -amany /Medical Due to (or as a consequence of): Examiner arterisclaritie Soquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examiner Due to (or as a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 14 Impatient 2 ER/Outpatient 3 DOA the funeral dir Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No м 2 Accident

Box 68760, o. Division of Vital Records, P.

Baltimore, Maryland 21215-0036

To the Hospital or Attanding Physicien:

Patrick,

State Registrar

Medical

29b. Signature and title of certifie

3 Suicide

29a. Certifier

4 Thomicide

31. Date filed (Month, Day, Year) 1 2004

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOKMO-57 NOVR 1 601- 5. Umlo m Que

29c. License number 21606

1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2□ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30/04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MO21028 Harredegraco

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24 hours a

within 24 hor To the Fune

(h n

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** PATRICK JOSEPH PAINTER SEPTEMBER 27, 2004 /Medical 1342 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**▼**M 2□F Yrs. Director 575-24-1790 91 JAN. 19. 1913 OKLAHOMA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28e-f show traumetic event, the Modical Era of er sust be notified at 10d. Inside City Limits 1 ☐ Yes 2 😿 No Director QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 915 CLOVERFIELDS DRIVE 21666 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No 1942—

If Yes, Give 1045 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: WHITE þ 3 ₩ Widowed 4 Divorced Year or Dates: 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ADMINISTRATOR RETIREMENT/WELFARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hitent: If item 27 is marked oth jury or other traumetic even Be ANTHONY BUELL PAINTER KATHERINE TROY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH POWERS/DAUGHTER 915 CLOVERFIELDS DRIVE, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State FORT LINCOLN 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page:
Department or
Importent: If i
any injury or
once. 09/30/2004 BRENTWOOD, MD CEMETERY 21. Signature of Fane a Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician emen disease or condition resulting in death) such Lase /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed an Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

of Vital Records, Division within 24 hours a To the Funerel I

Baltimore, Maryland 2121

Box 68760

P.0.

1667 CROETON MEDICAL CENTER. MIRZA M. NUSAIRED 32. Registra Signature State 0 2004 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

D 40519

29d. Date signed (Month, Day, Year)

CRUFTON.

9-29-04

	State of Maryland / Department of Health and Mental Hygiene 1. State of Maryland / Department of Health and Mental Hygiene 23a-c,25,27,28a-f_par.ME_C837_11/24/04dhb Reg. No. 1 1 2 2 2 5 5
G Q	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Physician /Medical	JAMES HOWARD ROBERTS September 8 2004 3:30 A M
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Holy Cross Hospital Silver Spring Montgomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year)
Director	504.30.3754
gu ≱	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
/anyli	Maryland Montgomery Silver Spring ¹∑Yes 2□No
with the Mar	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
Milh With	14016 Bethpage Lane 20906 U.S.A.
leath ns 23	
OO36 hours after death with the Maryland tural; or Itams 23e or 28e-f show at Examiner must be notified at ed by Funeral Director	Armed Forces? 1953 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
O3(3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1957 Specify: White
21215-003 ed within 72 hours ygiene. ygiene. t, It e Medical Exa	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working
within ene.	Elementary/Secondary (0-12) College (1-4or 5+)
a filed will Hygien other th	3 Years Training Director Insurance
	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
yla Ould the Menit the Marken Ma Marken Marken Marken Marken Ma M	
ore, Marylanc	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
O B B E E	Frances D. Roberts/Wife 14016 Bethpage Lane, Silver Spring, Maryland 20906 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore, permit. Pages ta permit. Pages ta permit. Pages ta limportant: If item any injury or othoones.	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
timen tant: tant:	`4 Donation 5 Other (Specify) Fort Lincoln Crematory 9/10/2004 Brentwood, Maryland
Bal Departiment Importiment any in	21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC.
402.00	11000 New Hampshire Ave. Silver Spring MD 20902
-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final Disease
Physician	Immediate Cause (Final disease or condition resulting in death)
/Medical Examiner	Due to (or as a consequence of):
ESESS.	Ecquentially list out difficult. if any, leading to immediate Due to (or as a consequence of):
nine	cause. Enter Underlying Cause (Disease partition)
160, The executed sician and buriat-transit earl Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):
	The state of the s
die the	d la manner
P.O. Box 68 The Certified at the death certified by the attending ph etached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Ciar Partie	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)
by the de tached	1 Yes 2 No 9 Unknown 9 Unknown
· + 5 0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
d by	Subdural Hematoma 1 Yes 2 No 3 Probably 4 Wunknown
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The law The law at the law page 2 sh	autopsy prior to completion of cause of performed? death?
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Vita	25. Was case referred to medical examiner? Yes ZM No Hospital: 1X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
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din din	TT.1. STORMAN
Wig of a line	Unknown 29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hosp within 24 hot To the Funa completely fill	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
within To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
1 0	1 (Onah M.D. 20056063 9/24/04
5	30. Name and address of person with completed cause of death (Item 23a) (Type, Print)
7	Kanwalgot Nagi, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature
Registrar	SEP 27 2004 Server 15 popular

		-	101	partment of Health and I Certificate of Death		ene g. No. 004 32867
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Francisca Romero de Vargas		Month September	Day Year 16:53 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Shady Grove Adventist Hospital	Rockville		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min.	(Month, Day, 1	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	*	Oct. 6,	1935 Nicaragua
	land		10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
	Mary f she	ō	Maryland Montgomery Rockvi	110		1 ਊYes 2 ☐ No
	r 28e	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	h with	0	1301 Edmonston Drive	20851	1	Nicaragua
	be filed within 72 hours efter death with the Maryland nat Hyglene. do other then "naturel", or Iteme 23a or 28e-f show event. The Maulical Examinar must be indiffical at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
9	or It		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ĀNo	1 XYes 2 No Specify:	3.00.7	Specify: White
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<u>a</u>	id be enta! ked o	To Be	Jose Angel Romero	Gracie	ela Aguirn	re
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Σ	alth a		Andrea Vargas / Daughter 130	Edmonston Drive,	Rockville	Maryland 20851
J.	of He of He I Item r oth		20a. Method of Disposition 20b. Place of D	isposition (Name of		Oc. Location - City or Town, State
Ē	Of Head			1 Cemetery 200		Managua, Nicaragua
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		21. Signature of Funeral Service Licensee MO1356	22. Name and Address of Facility Rolls Cockville, Inc., 30 Rockville, Maryland	bert A. Pu O West Mo	umphrey Funeral Home/ ontgomery Avenue,
	-		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			st, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Hamis		Onset and Death
	/Medical		resulting in death) a	VIVIVOC		VVIIIVIC 3
	Examiner		Sequentially list conditions, b.			
	ק ב	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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9 X	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atten for u	clan	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
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000	aw require ts been sig 2 should b	ompleted			24a. Was an	24b. Were autopsy findings available
Be	0 - 0	шо			autopsy performe	prior to completion of cause of death? 2 No 1 ☐ Yes 2 Ø No
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n of	ng Ph ter th neral		27. Manner of Death 12. Natural 5 Pending (Month, Day Year) 28b. Tim (Month, Day Year)		28d. Describe how	v injury occurred
<u>S</u>	Attending r death. ector: After by the fune	atle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
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	T 4 IT 0	Medical	29a. Certifier To CertifyIng Physician: To the best of my knowledge, of (Check only one) Medical Examiner: On the basis of examination and and manner stated.			
	To the within 2 To the complex	Mec	29b. Signature and utlenot centrier	29c. License number	290	d. Date signed (Month, Day, Year)
	F 3 F 8		I de la to mo	D053887		Bote mar 28, 2004
			30. Name and address of person who completed cause of death (Item 23a) (To	pe. Print)		gournal 20,2007
	10			Center Drive, Rockv	ille, Mar	√ yland 20850
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	£ 4		
	Registr		OCT 01 2004 Jenera	sports		

rn			1 - For Unpend Registrar	Iten	State of 23a, pt	of Mar	yland / [2 2 7, 28a	epai Cert	rtment of er me G	Health 836 1 Death	and M	lental H 04 ta:	lygier S	ne Na n n t	0000	0
			Decedent's Name (First, I									2. Date of I	Death	The state of the s	3. Time of Dea	th
	Physic /Medi		Karen Ann	Rar	nirez							Septer	nber	26, 20	04 10:20 A	М
	Exami		4a. Facility Name (If not insti			umber)			4b. City, Town,	or Location	of Death			4c. County of D		
Ç			240 West Hig	h St	reet				Elkton					Cecil		
	Funeral Director		5. Social Security Number 215-04-373	2	Sex 1 □ M 2 X F		38	rs.	If Under 1 Yea Months Days		r 24 Hrs. Min.	8. Date of I (Month, I Dec.	Birth Day, Yea 8	^{3r)} 1965	Birthplace (State or For Country) DE	eign
4	land		Usual Residence of Decede. 10a. State 10b. Co			10	0c. City, Town	or Loca	ation						10d. Inside City Lir	nits
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	e filed w Il Hygier other tl	Be C	17. Father's Name (First, Mic	idie, Las	t)			10 4.	50 "110	18. Moth	er's Name	(First, Midd		en Sumame))Id	
/lar	Venta	ToE	David Lee	Jor	es						An	na Ma	e W	heat1e	•v	
Maryland	s 1 and 2 should be filed I Health and Mental Hygi Item 27 Is marked other other traumatic event,		19a. Informant's Name/Rela	ionship	(Type, Print)		19b.	Mailing	Address (Stree	t and Numb				or Town, State		
	of Health item 27		Leticia Rar	nire	z/Daug		r_ 10	002	Woods	on Ro	d. A	pt. 1	, B	altimo		12
Baltimore,	ges 1 t of H If itel or oth		20a. Method of Disposition 1 🔀 Burial 2 ☐ Crema	ion 3 [☐Removal from		20b. Place of cemetery	Disposit , crema	tion (Name of story or other pla	ace)	D	ate	20c.	Location - City	or Town, State	
Ë	tmen tant:		`4 □Donation 5 □ Oth	er (Spec	ity)		Gilpi	in N	Manor		$\Delta \Delta \Delta A$	ber 7		Elkto	n, MD	
Bal	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funerar Ser	1				Ar	l _{am} Park ndrew	G. Ge	e Fi	unera	1 H	ome	0.1.0.0.1	
Г			23a. Part1. Enter the diseas shock, or heart failure.	e, or con List only	nplications that one cause on	caused the each line.	e death. Do no	ot enter	the mode of by	ing, such as	cardiac o	respiratory	arrest,	on, ML	Interval Between	
	Physician	Ì	Immediate Cause (Final disease or condition resulting in death)		a. Metl	hadon	e Into	xica	tion						Onset and Death	
	/Medical- Examiner		resulting in death)		Due to	(or as a co	onsequence o	f):								
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	- 1	b. Due to	(or as a co	onsequence of	f)-								
	nted insit	Examiner	Cause (Disease or injury	~		(0. 00 0.	571 3 04 3 071 0 0	17-								
,	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last		c. Due to	(or as a co	onsequence of	f):						_		
68760,	cate be ex physician the buria	dical		Į	d											
_		0		-												
.O. Box	that the death certificated by the attending properties of the control of the control of the certification of the	Physician/M	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown			birth 2 [nant at tim	Fetal death		ctopic pregnanc other (specify) _	y				23d. Date of d Month	lelivery Day Year	
<u>α</u>	res that the igned by th be detache	by Pr	Part II. Dther significant cor	ditions	contributing to c	death but n	ot resulting in	the unde	erlying cause gr	ven in Part I		23e. Did	tobacco	use contribute	to the cause of death?	
rds	- 07 73	ed p	Cocaine Use									1	Yes 2	2 □ No 3 □	Probably 4 tounkno	wn
I Records,	The law ate has b page 2 s	Completed										24a. Wa auto per 1V Yes	s an opsy formed?	death		ble of
Vital	ysicien: Th iis certificate director, pag	Be	25. Was case referred to me examiner?	dical						26. Place	of Death	(Check only	one)			
of	ys di S	2	1 XYes 2 □ No				2 ER/Outp		3 L DOA						ecity) at scen	e
	ling After une	lon:	27. Manner of Death 1 □ Natural 5 □ Pe		28a. Date	of Injury oth, Day Ye	Par) 28b. Ti		28c. Inju Wo	rk?		8d. Describe	how inju	ury occurred		
<u>si</u>	Attending r death. sctor: After by the fune	icat		estigatio uld not b termined	9-26	-04	9.3	5 A		Yes 2 🟋		Inknow				
Division	in Sire	Certification;	4 Homicide	termined	_ Dullu	ing, etc. (S d at	Police	11, 5(166)	t, factory, office		1	City or To	own, Stat	(a) 240 W	High St.	
	To the Hospitel or Attenwithin 24 hours after deals To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifier (Check only one)	ifying Pl cal Exa	hysician: To the miner: On the b	e best of m	ny knowledge, amination and/	death o	ccurred at the ti	me, date an opinion, dea	d place, a	Elkton nd due to the d at the time	cause/s	s) and manner :	as stated. ue to the cause(s)	
	To th withir To th compa	Me	29b. Signarate and title of ce	tifier	(20	0		29c. Licens	oe number	E'			ate signed (Mo		
			30. Name and address of per	son who	completed caus	se of deputh	(Item 23a) (T		nt)						27, 2004	
	Sta	te	31. Date filed (Month, Day, Y	ear)	FORICA 22. F	Registrar's)111		street	, Bal	Ltimor	e, M	aryland	21201	
	Registr	-	OCT 4	200	Bud	w ,	Signature A	rolle	,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 27, 2004 **Physician** 0122 A M Cleo Patra Robinson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S MALCOLM GROW MEDICAL CENTER CAMP SPRINGS 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF Yrs. Hopkinsville, Ky 69 July 3, 1935 Director 404-40-8095 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ir than "netural", or items 23a or 28a-f e-how the Medical Examiner must be notified at 1X Yes 2 No Maryland Prince Georges Forestville Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20747 1913 Ritchie Rd. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Legal Clerk Government . Pages 1 and 2 should be filed v trent of Health and Mental Hygie tant: If Item 27 is marked other t ijury or other treumatic event, to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mosie Lee White John Thomas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn Jeter / Daughter 1113 Egyptian Dr. Upper Marlboro, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or Oct.1, 2004 Resurrection Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) Alexander S. Pope Funeral Homes, P.A. 5538 Mariboro Pike/Forestville, Md. 21 Signature of Funeral Service Lice 23a. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 HOURS Physician a UPPER GASTROINTESTINAL BLEED /Medical Due to (or as a consequence of) **Examiner** METASTATIC BREAST CANCER 15 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ been signe should be 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Npatient 2 ER/Outpatient 3 DOA Medical Certification; To 1 Yes 25 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Alter 1 XNatural 5 Pending investigation after death.

Director: All 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) title of certifier 29c. License number 29b. Signature and SEPTEMBER 27,2004 01043261A INDIANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 89 MDG/1050 W. PERIMETER RD. BARBARA A. COOPER, CAPT, USAF, MC ANDREWS AIR FORCE BASE, MD 20762-6600 31. Date filed (Month, Day, Year, Registrar's Signature State SEP 3 0 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 29, 2004 10:47 AMM **Physician** BENJAMIN E. RICHARDS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 16507 Milltown Landing Road Prince George's Brandywine If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1**X**M 2□ F Yrs. 87 AUG 2 1917 Maryland Director 217-32-1918 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16507 Milltown Landing Road 20613 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1X) Yes 2 □ No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) County al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) County Police Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental Hitant: If item 27 is marked other. William Richards Dora Canter Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Lee Richards (wife) 16507 Milltown Landing Rd. Brandywine, MD 20613 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurfa 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. Brookfield U.M. Church 10-1-04 Upper Marlboro, MD 4 □ Denation 5 □ Other (Specify) 21. Sign we of Fyseral Symbol Licensee 22. Name and Address of Facility Eberwein Funeral Services M00173 benue 4433 White Pls. La. White Pls., MD 20695 At1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final heart for ture Congertius **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinite date cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records. sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🗓 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 · lame Soptember 30, 2004 D 035206

Registrar

DHMH 17 Rev 1/2001

Men & Species **ORIGINAL**

William Tanner, M.D. 11701 Livingston Rd #101 Ft. Washington, MD 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) SEP 3 0 2004

		State of Maryland	Certificate			iene _{ig. No.} 20 (14 3287	7
Physician /Medical	Decedent's Name (First, Middle, Last) IRENE MARTIN	ROLAND			2. Date of Deat Month Septemb	Day Y	3. Time of Dea 2004 4:0	
Examiner	4a Facility Name (If not institution, give s Charles County		2	4b. City, Town, o	r Location of Death	4c. County of		
Funeral Director	5. Social Security Number 6. Sex		st birthday) If Under 1	Year If Under 24 H	s. 8. Date of Birth	Year)	Birthplace (State or For Country)	reign
show show	10a. State 10b. County	· ·	Town or Location				10d. Inside City Li	
or 28a-f sho or 28a-f sho or notified	MD Charles 10e. Street and Number	Nan	jemoy 10f. Zip Ci	ode	10	Og. Citizen of Wh		
uter death with the Mai r fems 23s or 28s-fs other must be notified Funeral Director	2925 Port Tobac	CO Road 2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 A No	13. Was Deceder	562 It of Hispanic Origin? Cuban, Mexican, Pue	Specify Yes or No-	USA 14. Race	American Indian,	
	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 Ž No If Yes, Give Year or Dates:	1 ☐ Yes 2X		nto Filcan, etc.)	Specify:	White, etc. White	
d within jiena.	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cetion completed) College (1-4or 5+)	16a. Decedent's Usual C (Give kind of work of the DO NOT use) Clerk	Occupation done during most of w retired)	orking	ederal	Governme	n t
Mantal Hygi Mantal Hygi arked other atic event, I	17. Father's Name (First, Middle, Last)	N			ame (First, Middle, N	faiden Surname)	- VO Y O Z IMIOI	
2 should by and Mante is marked raumatic or	Fletcher David 19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing Address (S	treet and Number or F		City or Town, St		
Pages 1 and 2 should be filed ent of Heath and Mantal Hyg wit if I flean 27 is marked other ry or other traumatic event, To Be C	Joan Silbaugh/da 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	2925 Port ce of Disposition (Name netery, crematory or othe 1 Durham	i piace)				2
Department of Important: If any injury or DOCS.	21. Signature of Funeral Service License	*M00945	A22 emand	dd Es of Facility	10/1/04 Funeral Ave. La	Home.		
chriticals to executed ding physician and ding physician end make the burial-transit se es the burial-transit and make the purial-transit and make the purial-transit and make the purial examiner.	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		is a consequence of): is a consequence of): is a consequence of):	ACHT CA	DIJEA	ne	FEW MIN	me
a death of the attence of for unset	Part II. Other significant conditions cont	ributing to death but not resulti	ng in the underlying caus	e given in Part I.	23b. Did tob	acco use contri	buta to tha causa of de	ath?
v requires that the death certifued in the strength of the str	CONGESTIVE	HEART	FAILU	RE	1 □ Ye	s 2□ No 3	□ Probably 4 Unkr	nown
The lew requires that the death certicate has been signed by the attending pega 2 should be datached for use completed by Physician/M					24a. Was an perform		24b. Were autopsy finding available prior to completion of cause of death?	-
nystcian: The lew his certificate has b I director, pega 2 s To Be Compl	25. Was case referred to medical			26 Place of De	1 ☐ Yes	11	1 ☐ Yes 2 ☐ No	
	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 2 EF 28a. Date of Injury (Month, Dey Year)			Home 5 Resider	nce 6 □Other	Specify)	
tal or Attending Pi is after death. al Director: After it lad in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, of	fice	28f. Location (Stre City or Town,	eet and Number (State)	or Rural Route Number,	
To the Hospital within 24 hours a To the Funeral D complately filled Medical Ce	29a. Certifier (Check only one) 1 ▼ Certifying Physical Examine	cian: To the best of my knowle or: On the basis of examination and manner stated.	edge, death occurred at the and/or investigation, in	ne time, date and plac my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manne te and place, and	er as steted. I due to the cause(s)	
vithir To th comp	29b. Signature and title of certifier		29c. Li	cense number	29	d. Date signed (A	Month, Day, Year)	2004
Zi	30. Name and address of person who con	npleted cause of death (Item 23	3e) (Type, Print)	Mala	0 114	FILT	UD 20602	
State Registrar	31. Date filed (Monts Pay Year) 20	32. Figistrar's Signature	0 1/10	METION	WA	CUT	20602	

DHMH 16 Rev 6/95

		·	1 - For State of Maryland / Department of Heal Certificate of Deal	ath	Reg. No. 004	32872
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year	3. Time of Death
	/Medic	al	Herbert Thomas Reader, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loca	Sept	. 29, 2004 4c. County of Dea	9:40P M
	Examin	er	464 Nottingham Rd. Elkton	and of boats	Cecil	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 1 Age (In yrs. last birthday) Months Days Ho	Juder 24 Hrs. 8. Date of (Month) Feb.	Birth 9. Bir Day, Year) Co	thplace (State or Foreign ountry) DE
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ours after death with the Marylar rat', or items 23a or 28e-f show Examirer must be notified at	to	MD Cecil Elkton			1 ☐ Yes 2 🌠 No
	th the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	ath wi	rai	464 Nottingham Rd. 21921		U.S.A.	
	er des items	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Specify Yes or exican, Puerto Rican, etc.)	r No- 14. Race - Ame Black, Whit	
336	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Sp Year or Dates:	pecify:	Specify: Wh	nite
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28e-1 show olical Examinations the notified at		15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	n most of working	16b. Kind of Business	Industry
21		Completed	Elementary/Secondary (0-12) College (1-4or 5+)			
	77 77		9 _ Shipping & F	Receiving Mother's Name (First, Mid	Thiokol	Corp.
Maryland	o d ab o	o Be	Dender and Dender			
ary.	P E E	F	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and N</i>	Estelle Ro: Number or Rural Route Nu		Zip Code)
	and 2 stath ar		Flora Reader/Wife 464 Nottingha	m Rd., Ell	kton, MD 2	1921
ore	ges 1 and t of Healt If itam 2 or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	
Baltimore,	permit. Pages Department of I mportent: If it. sny injury or o	1	`4 Donation 5 Other (Specify) Gracelawn Memori	.ar 2004	D, Wilmin	igton, DE
Bal	permit. Pag Department Importent: any injury c	i a	21. Signature of Function Science Park 22. Name and Address of I Andrew G.	Gee Funera		21021
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	ch as cardiac or respirator	Figer on, MD	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			
	Examiner		Sequentially list conditions Due to (or as a consequence of): Primary Pulmonary 114pe	artension		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	O TCVISION T		
	nd nd rransit	Examiner	triat initiated events c.			
90,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	physicate t	dicai	d			
Вох 6	death certifica attending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of del	iverv
	death e atter	iciar	in the past 12 months? 1		Month	Day Year
P.0	at the by th	hys	9 Unknown			
of Vital Records, I	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I		lid tobacco use contribute to	
ecc	law ri	Completed		24a. W	Mas an 24b. Were au prior to d	topsy findings available completion of cause of
E E	: The cate har, page	Con		1 □ Ye	erformed? death?	
Vita	Physicien: Th this certificate ral director, pag	Be	examiner?	Place of Death (Check on		12021
	Phys arthis aral di	To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		esidence 6 Other (Spec	cify)
<u>io</u>	ittanding death. ctor: After / the funer	aţio	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes	2 🗆 No		
Division	f or Attanding after death. Director: After I in by the fune	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street and Number or Ru Town, State)	ral Route Number,
0	oital o urs afi oral Di			<u> </u>		
	Hosp 24 ho Fund stely fi	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, da 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, and due to t n, death occurred at the tin	the cause(s) and manner as ne, date and place, and due	stated. to the cause(s)
	To the Hospital or Att. within 24 hours after de To the Funeral Direct. completely filled in by the	Med	29b. Signature and title of certifier 29c. License num	nber	29d. Date signed (Monti	n, Day, Year)
	, . ,		Deforbygyn MD 00059	7131	September 3	0, 2004
	6					-
		ļį.	Thomas Duggan, mo 207 North Street. &	11ston no	21921	
	Sta Registr	_	30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Thomas Duggan, mo 207 North Street, E 31. Date filed (Month, Day, Year) OCT 4 2004			

Registrar

Rowan

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	1	For State Registrar			Marylar	•			ealth a	and M		Reg. No.	not	1 1	328	74
Physician /Medical Examiner		1. Decedent's Name (Firs Alexand 4a. Facility Name (If not in 9265 Crai	ler			Semi	4b. City,	Town, or	Jr. Location of	of Death	2. Date of Dea Month October	Day 7	2004 County of			30A ^M
Funeral Director		5. Social Security Number 229-56-032	.9 15	XM 2□F	7. Age (In yrs. 62	last birthday) Yrs.		1 Year Days	If Under		8. Date of Birt July	Year)	g	. Birthpl	lace (State of	or Foreign La
e Maryland aa-f show diffied at		Usual Residence of Dece 10a. State 10b. MD	County Char	les	10c. Cit	y, Town or Lo		n								ity Limits
th with th		10e. Street and Number 9265 Crai	n Hwy,	Apt.	100		10f. Zip		2061	1		10g. Citi	USA	at Coun	try?	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene if the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinating the indiffed at To Be Completed by Funeral Director		11. Marital Status 1 Never Married 2 3 □ Widowed 4 □ □		12. Was Deced Armed For 1 ☐ Yes If Yes, Give Year or Da	ces? No		Was Decedif Yes, spen		ispanic Ori in, Mexican Specify:	gin? (Spe i, Puerto i	ecify Yes or No- Rican, etc.)	-	14. Race - Black, Specify:	White,		<u> </u>
ed within 72 horygiene. ner than "natura". it, the Medical E.	-	15. C (Specify oni Elementary/Secondary 12	ecedent's Edu ly highest grad (0-12)	cation e completed) College (1-	4or 5+)		dent's Usu kind of wo DO NOT u isab	rk done d se retired	ation during mosi l)	t of workii	ng	16b. Ki	ind of Busi	ness/Ind	lustry	
hould be filed d Mental Hygi marked other matic event, I		17. Father's Name (First, Alexande 19a. Informant's Name/R	r Sem		,Sr.	19h Maili	o Address	(Street	E1:	izab	(First, Middle, eth Ba Il Route Numbe	atta	a	ate Zin	Code)	
and 2 should be file and 2 should be file asth and Mental Hy n 27 is marked oth er traumatic event To Be (Walter Se				908	Bar	ring	gton	Dr.	Walde					
perr it. Pages 1 a Deportment of Hee Important: If item any njury or othe once.		20a. Method of Disposition 1 Burial 24 Cre 4 Donation 5 0 21. Signature of Funeral	mation 3 🗆 P Other (Specify)			Place of Dispo cemetery, creating nsfie 45	ld-E	cho:	ls 1	0/1	6/04 FUNERA	Cł	nar10	otte	e Hal	1,MI
Physician properties of the price of the pri		23a. Part1. Enter the disshock, or heart failu Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Unide lying Cause (Disease or injury that initiated events resulting in death) Last	re. List only of	Due to (c	or as a consector as	th. Do not end quence of):	P.O. er the mod	BO de of dyin	X 56 g, such as	7 T.A cardiac o	PIATA	A MI	206	546	Approxima Interval Bet Onset and	tween
the death y the atter sched for u	_	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nant		th 2 ☐ Feta int at time of c	Ideath 3	⊒Ectopic p ⊒ Other (sp		·				23d. Date o Month			Year
aw requires the second be described by the describing the described by the		Part II. Other significant	conditions co	ntributing to de	ath but not res	sulting in the u	nderlying o	ause give	en in Part I.		1 🗆 Y	res 2	□No 3	Proba	e cause of cably 4 15 bosy findings appletion of c	Unknown
	,	25. Was case referred to	medical						26. Place	of Death		2 X No			2 □ No	
ding Phys	2	2 Accident	Pending investigation		patient 2 [f Injury n, Day Year)	28b. Time o Injury		28c. Injun Worl	4 🗀 NU	2	ne 5 Residence 28d. Describe h			(Specify)	
talor rs afte al Dire ed in I		4 Homicide	Could not be determined	buildin	of Injury - At h g, etc. (Speci	(y) 					28f. Location (S City or Tox	vn, State	·)			nber,
To the Hospi within 24 hou To the Funer completely fill Medical		(Check only one)	Medical Exami	sician: To the ner: On the ba and mann	sis of examina	ation and/or in	vestigation	, in my o	pinion, dea	th occurre	ed at the time,	date and	i place, and	due to	the cause(s	s)
To the To the Complex		29b. Signature and title o	~ M.	-					5088	33		29d. Dat	te signed (Month, I	Day, Year)	
6		30. Name and address of Yahia M.						pp I	21ace	e.La	Plata	а МГ	206	46		
State Registrar		31. Date filed (Month, Da			gistrar's Sign			Kar		,		,				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of		nd / Depa		of H	ealth ar		ntal Hygie	ene	ible.	32975
			Decedent's Name (First, Middle, La	ast)			imouto	0, 2		2	. Date of Death	No.	1 1-9	3. Time of Death
	Physici		Paul Joseph Scu	llen							Month Septembe	Day	Year	
4.	/Medic Examir		4a. Facility Name (If not institution, gi		ber)		4b. City, T	own, or	Location of		оерестье	4c. County		1.50
	LXajiiii		3141 Wheaton Way						t Cit					
	Funeral					. last birthday)	If Under 1	Year	If Under 24	4 Hrs. g	. Date of Birth		ward 9. Birth	place (State or Foreign
	Director		216-60-1007	½ □M 2□F	53	Yrs.	Months	Days	Hours	Min.	(Month, Day,)	^{'ear)} 1951	Was	place (State or Foreign intry) hington, DC
	p.		Usual Residence of Decedent											3
	ahow	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Be-f	cto	Maryland Howard	<u> </u>	E	llicott	City							1 ☐ Yes 2 ☐ No
	章 og a	Director	10e. Street and Number				10f. Zip C	Code			100	. Citizen of	What Cou	ntry?
	ath w	-a	3141 Wheaton N	Way, Apt.	C		210	043				USA		
	tems	by Funeral	11. Marital Status	12. Was Deced	es?	J.S. 13.	Was Decede f Yes, specif	nt of His y Cuban	spanic Origin n, Mexican, I	n? (Specit Puerto Ric	y Yes or No- can, etc.)		e - Ameri ck, White,	can Indian,
36	or l	Y	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give			1 Yes 21		Specify:				y:Whit	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28e-f ahow the Madical Examinar must be invitted at	D D	3 Widowed 4 Divorced	Year or Da	es:	10: B						3000		
<u>.</u>	n 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual kind of work DO NOT use	done di	urina most o	of working	16	ib. Kind of B	usiness/In	ndustry
2	withi ene. than	ᄩ	Elementary/Secondary (0-12)	College (1-	4or 5+)			,						
2	filed Hygi thar	ŭ	17. Father's Name (First, Middle, Las.	t)		Car	pente:		18. Mother's	s Name (/	First, Middle, Ma	Rêmo		1g
an	d be antal	To Be	Anthony James 5							Fil:		oon caman	,,,	
Maryland	shout nd Me mark marti	Ĕ	19a. Informant's Name/Relationship			19b Mailir	ng Address /	Street au			Jace Route Number, C	City or Town	State Zie	Code)
<u>8</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents If item 27 is marked other than "natural", or Items 23a or 28e-f ahow amy injury or other traumatic evant, the Medical Examinar must be notified at once.		Ellen Scullen/ Wi											MD 21043
ค์	Hear Hear		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name	of		Date	20	c. Location -		
9	age:		1 ☐ Burial 2 🖾 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		ate M	cemetery, cren letropo		er place) ¦Oc	tobe 2004		1		***
altimore,	artm. F orter injur		21. Signature of Funeral Service Lice			Crema		Address	of Facility					Virginia
ő	Dep Imp		1 da 5	0-6		F'1	rancis 00 Uni	J. vers	Colli sity B	ns F	uneral I	Home I	nc.	, MD 20901
			23a. Part1. Enter the disease, or com	plications that ca	used the dea								ring	Approximate
Ь	Williams.		shock, of heart failure. List only Immediate Cause (Final	one cause on ea	ch line.			, ,			, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Pround	onia rasa consec	auonao of):							-	7 Days
0	Examiner			Frd C		irrhosi							1	C Mars the se
Ļ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury		r as a consec		LS						-	6 Months
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	C										
ó	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last	Due to (o	as a consec	quence of):								
760,	ate be nysici	cal		d										
39	ng ph as th	Med	IF FEMALE:											
Box	leath certific attending p	an/	23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pred	nancy				23d. Dat	e of delive	эгу
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of c		Other (spec					Mo	nth	Day Year
о. О	at the de I by the a stached	Physician/Med	9 Unknown											
Ś	The law requires that the tee has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the ur	nderlying cau	ise giver	n in Part I.		23e. Did tobac	co use conti	ibute to th	ne cause of death?
ecords,	w require been si should b	ted								-	1 🗆 Yes	2 🗆 No	3 Prob	ably 4 Junknown
ပ်	law las b	Completed									24a. Was an autopsy	24b. V	Vere auto	psy findings available impletion of cause of
		Con									performed 1 ☐ Yes 2 X	d? c	leath?	
Vita	in it is	Be	25. Was case referred to medical examiner?							Death (C	heck only one)			
ot	Phyaicle this cert	2	1 ☐ Yes 2X No	Hospital: 1 🗆 Inp		ER/Outpatient	t 3□ DOA	Other	4 🗆 Nursii	ing Home	5 🛭 Residenc	e 6 ⊡Othe	er (Specify	y)
ב	ding F h. After funera	lon	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		: Injury a Work?			. Describe how	injury occurr	ed	
S	Vttendi death. ctor: A y the fu	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		∍s 2□No	-				
Division	or Al	Certification;	4 Homicide determined	28e. Place o	l Injury - At h , etc. <i>(Specil</i>	ome, farm, stre fy)	et, factory, c	office		28f.	Location (Stree City or Town, S	t and Numbe Itate)	er or Rura	I Route Number,
_	tha Hospital or Attending hin 24 hours after death. tha Funaral Diractor: After npletely filled in by the fune		29a, Certifier 1 X Certifying Pt	<u> </u>						1				
	Hos 24 ho Funi	edical	29a. Certifier 1 ★ Certifying Pl (Check only one) 2 ★ Medical Example (Check only one)	niner: On the bas	is of examina	owledge, death ition and/or inv	occurred at estigation, in	the time my opir	, date and p nion, death c	olace, and occurred a	due to the caus at the time, date	e(s) and ma and place, a	nner as st ind due to	ated. the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	Med	29b. Signature and title of certifier	and manne	stateu.			icense i				Date signed		
	with Con		Allo Do	1 D: 1	000			D433				sept.		
	6		20 Name and address of	17U	of death "	- 02-\ (T							, _	
	-		30. Name and address of person who Abeda Ali Khan					76 D	024	Co 3	nbia, MD	. 2124	4	
	∮ Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa		-			COLUM	ibia, ML	<i>∠</i> 104	±	
	Registr	-	OCT 01 20	9	was	19	pour	Ks						

			For State	State of Mary				Mental Hy	0000	
	_	_	RegistreMEND#26perMD9/3 1. Decedent's Name (First, Middle, Last)	80/04,BMW,MbCc	o Cei	rtificate of	Death	0.000	Reg. No.	<u> </u>
	Physici	an	Addie L.	Smit	h			2. Date of De	Day Year	- N
	/Medic Examin		4a. Facility Name (If not institution, give s		11	4b. City, Town, o	r Location of Dea		ber 28, 200 4c. County of Dea	4 3.30
			The Elternhaus			Dayton			Howard	
	Funeral		5. Social Security Number 6. Sex	7. Age (Ir	n yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 9. Bi	rthplace (State or Foreign country)
	Director		217-32-1166 Usual Residence of Decedent		00 110.		1	Apr. 2,	. 1916 N	ew York
	/land		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Man,	ţō	Maryland Prince	George's	Hyatts	ville				1 ☐ Yes 2 🖾 No
	r 28g	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	th wit	ai	5100 Decatur St	treet		20781	i		USA	
	dea	Funerai	11. Marital Status	2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No		
98	or it		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:	, to 1 lloan, 0to.)	Specify: Wh	
8	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show iteal Examirat must be motified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:						
21215-0036	"nat	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of we	orking	16b. Kind of Business	Mndustry
12	within ene. than "	mc.	Elementary/Secondary (0-12)	College (1-4or 5+)			-/			
9	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)		HOII	nemaker	18. Mother's Na	ame (First, Middle	Own Hör , Maiden Sumame)	ne
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene the flam 23 or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I're McJical Expriner mast be notified at	To Be	Alfred Bowen				Mable	Button		
ary	should and Men s marks umatic		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street			er, City or Town, State,	Zip Code)
	1 and 2 Health a lam 27 is		Betty J. Roberts/	Daughter	5100	Decatur	Street,	Hyattsv	ille, MD 20	0781
ore	of He of Hitam		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	1	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place n Memoria	e) Sept	Date ember 29,	20c. Location - City or	Town, State
Ĕ	Pages ment of I		* 4 □ Donation 5 □ Other (Specify)			n Memoria ark	11	2004	Rockville,	Maryland
Baltimore,	permit. Pages Department of Important: If i any injury of once.		21. Signature of Funeral Service License	0	22 F:	Name and Addre	ss of Facility	s Funeral	l Home Inc.	
	σΩ ≒ e O		(mohen)	Lole	50	00 Univer	sity Blv	vd, W, S:	ilver Sprin	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	death. Do not ent	er the mode of dyin	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician	7	Immediate Cause (Final disease or condition resulting in death)	Who	rulere	5				JU)
	/Medical Examiner		Tooling in county	Due to (or as a co	onsequence of):					J
	3	-	Sequentially list conditions, if any, leading to immediate	. Due to (or as a co	onsequence of):					(fix)
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
o,	an an rial-tr	Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
68760,	cate be executed physician and the burial-transit	dicai	d							
			IF FEMALE:							-
Вох	death certifi e attending id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
0.	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	e of death 5	Other (specify)			W.S.I.B.	buy Tour
Δ.	de de		Part II. Other significant conditions con	tributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	uires n sign	d by						1 🗆 🕆	Yes 2 □No 3 □ Pi	robably 4 Unknown
00	w requ	lete						24a. Was	an 24b. Were a	utopsy findings available
Re	Ф г Ф	Completed						autop perfo	prior to death?	completion of cause of
	i ician : Th certificate rector, pag	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only o		2 No
Į <	di is	To B	examiner?	ospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Oth		/	6 ☐ Other (Spe	city)
			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injun	y at k?	28d. Describe h	now injury occurred	
sio	Attanding in death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No			
Division	ial or Attandi s after death. al Diractor: A ad in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or Ri vn, State)	ural Route Number,
	pital ours a aral (29a. Certifier 1 Certifying Phys	iciant To the best of m	v knowledge, doeth	and the time	no data and nine	a and due he she		
	To the Hospital or, within 24 hours after a To the Funaral Dire completely filled in L	edical	(Check only one)	er: On the basis of exa and manner stated.	amination and/or inv	restigation, in my o	pinion, death occ	urred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
	ro the within Fo the Somple	Me	29b. Signature and title of certifier	1		29c. License	e number		29d. Date signed (Mont	h, Day, Year)
	4		* STATE	Can Mis		7311	72	-	Sofater 28	2004
	1		30. Name and address of person who con			Print) Harry	Andrew		. D.V	1
	1		H.A 4651 MI	0 10700	CHANTE	n DA	200 (DWAB.	A MD.	4094
	Sta Registr		31. Date filed (Month, Day, Year) SEP 3 0 2004	32. Registrar's	Signature	Sporks	/			- 1

Physician /Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

by Physician/Medical

Be Completed

Medical Certification: To

Funeral Director

State Registrar		•	•	cate of D		Mental Hyg R	eg. No.	00		32875
Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	th Day	,	Year	3. Time of Death
DAVID I	UZJAN SLO	JKOWSKI	Ε			SEP 2		2004	l bai	7:20 P
Fecility Name (If not institution, give			4b.	. City, Town, or Lo		h	4c.	County of	f Death	
NATIONAL NAVAL ocial Security Number 6. S		NTER (In yrs. last bir	etholou) If I	BETHI Under 1 Year	ESDA f Under 24 Hrs.	R Date of Birth		MONT		RY lace (State or Fore
	M 2 F			onths Days	Hours Min. 17	8. Date of Birth (Month, Day 09/25/2	Year) 004		Coun	YLAND
State 10b. County NON.		10c. City, Tow WASH	m or Locatio						10	0d. Inside City Lim
. Street and Number			10	Of. Zip Code		1	0g. Citi	zen of Wh	nat Coun	itry?
1587-D ELGIN W.	AY, BOLLING	G AFB		200	32		U	SA		
Marital Status X Never Married 2☐ Married ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No tf Yes, Give Year or Dates:				anic Origin? (S Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)			White,	
15. Decedent's E (Specify only highest gra ementary/Secondary (0-12)			(Give kind	s Usual Occupation of work done duried (ICT use retired)	on ing most of wor	rking	16b. Ki	nd of Busi	iness/Inc	dustry
ONE	1	N	ONE		Nother No.	me (First, Middle,		NONE)	
Father's Name (First, Middle, Last, ICHAEL SLOJKOWS)				18		DONAHUE		Sumame,	,	
. Informant's Name/Relationship (-			ural Route Numbel				
Mathad of Dissocities					The state of the state of					
1 ☐ Burial X ☐ Cremation 3 ☐		cemeter	ry, cremator	n (Name of ry or other place)	00/2			cation - C		
1 □ Burial X □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	5)	cemeter	S & TI	ny or other place)		0/04	STA	FFORD	,VII	RGINIA
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content of the cont	5)	cemeter	S & TI	HOMPSON me and Address	of Facility M		STA)	FFORD OMPSO	,VII	RGINIA JNERAL HO
1 □ Burial	nsee Older	MULLIN	22. Na. 162	HOMPSON me and Address (of Facility M	0/04 ULLINS & Y.,FREDE	STAI THO RICI	FFORD OMPSO	,VII	RGINIA JNERAL HO A 22401 Approximate
1 Burial Cremation 3 C 4 Donation 5 Other (Specification of Funeral Service Lice) 1. Part 1. Enter the stase, or complete shock, or heart for re. List only neediate Cause (Final page or condition	plications that caused to one cause on each line	MULLIN	S & TI 22. Nat 162. not enter the	HOMPSON me and Address (of Facility M	0/04 ULLINS & Y.,FREDE	STAI THO RICI	FFORD OMPSO	,VII	RGINIA JNERAL HO A 22401
1 Burial Cremation 3 L 4 Donation 5 Other (Specific Signature of Funeral Service Lice) a. Part1. Enter the sase, or complete Shock, or heart hours. List only mediate Cause (Final ease or condition ulting in death) quentially list conditions, ny, leading to immediate see. Enter Underlying	psee Disaster of the control of the	MULLING the death. Do it. EMATURI consequence	S & TI 22. Nai 1623 not enter the	HOMPSON me and Address (of Facility M	0/04 ULLINS & Y.,FREDE	STAI THO RICI	FFORD OMPSO	,VII	RGINIA JNERAL HO A 22401 Approximate Interval Between
1 Burial Cremation 3 L 4 Donation 5 Other (Specific Signature of Funeral Service Lice) a. Part1. Enter the sase, or come shock, or hearth size. List only nediate Cause (Final passe or condition ulting in death) quentially list conditions, ry, leading to immediate see. Enter Underlying tes (Underlying test of the same see.)	pplications that caused to one cause on each line. a. PRI Due to (or as a b. Due to (or as a c.	the death, Do e. EMATURI consequence	S & TI 22. Nat 162.1 not enter the CTY of):	HOMPSON me and Address (of Facility M	0/04 ULLINS & Y.,FREDE	STAI THO RICI	FFORD OMPSO	,VII	RGINIA JNERAL HO A 22401 Approximate Interval Between
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State

AGNES STEROCKA MA 31. Date filed (Month, Day, Year) SEP 3 0 2004 Registrar

30. Name and address of

MC USA 32. Registrar's Signature Breche

MAJ

e of death (Item 23a) (Type, Print)

BETHESDA MD 20889-5600 oaks!

01051105A (IN)

NATIONAL NAVAL MEDICAL

CENTER

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	110000			and /, D		nt of H	ealth and	Mental Hy			32878
Physician /Medical Examiner	ŀ	1. Decedent's Nam	Doris Ju	ine Sch	umber)	Marko	4b. City,		Location of Dea	2. Date of De Month O 9	30 4c. Cou	Year 6 4 Inty of Death	
Funeral Director	_	<i>Pen I n s U A</i> 5. Social Security N 578-40-	lumber 6.	<i> </i> Sex 1 □ M 2 □ X F	7. Age (In y		nday) If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min		th ay, Year)	9. Birth	nplace (State or Foreign untry)
iffied at		Usual Residence o 10a. State MD	10b. County Worces	ter	10c.		or Location v Hill						10d. Inside City Limits 1 X Yes 2 □ No
s 23a or 28e-f s cust be notified erai Director		10e. Street and Nu 410 W. 11. Marital Status	Market		cedent Ever ii	2118	2	21863	spanje Origin? (Specify Vac or No	US	of What Cou	
ral', or items 23¢ Examinar must	5		ied 2☐ Married 4☐Divorced	Armed F	forces? 2 ∑∜ No live	0.3.	If Yes, spe		Specify:	Specify Yes or No rto Rican, etc.)	1	Black, White	e, etc.
ygiene. ner than *natura it, the wedget t	and line	(Spec	15. Decedent's E cify only highest gr ondary (0-12)	ade completed	(1-4or 5+)	- '	Decedent's Usu (Give kind of wo life. DO NOT u	ork done d ise retired)	uring most of we	orking	16b. Kind o	f Business/l	•
Mental Hyg arked other attic event, I	2		Patrick M	lcKenna					Clar	ame (First, Middle a Muzyd	la		
Health and lem 27 is m other treum	-		ame/Relationship C. Schn position		20	710 b. Place of	00 Ward	dman	Rd., E	Bural Route Numb Baltimore		21212	
Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23a or 28e-f show any njury or other freumatic event. Its Widgal Examinating the mailling at once. To Be Completed by Funeral Director		¹ 4 □ Donation	Cremation 3 [5 □ Other (Special Juneral Service C	fy)	State (-	22. Name a	en Cr	ematory	1-04 / The Bur Serlin, M	bage F	unera	Delaware I Home
physician and may be solved in the burial-transit physician and physicia		Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death)	onditions, nmediate erlying injury s	a. OCC Due to Due to c.	1	sequence o	ve f):						Onset and Death
for use a:	and a second	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	? months?	1 ☐ Live	utcome of pre birth 2 F gnant at time on nown	etal death	3 ☐Ectopic p 5 ☐ Other (s)					Date of delive	very Day Year
be o	2	Part II. Other signi	ficant conditions					cause give	n in Part I.	23e. Did t	/		the cause of death?
tificate has been s tor, page 2 should e Completed		25. Was case refe	ared to modical		,					1 Tes	psy prmed? 2 2 No	prior to death?	topsy findings available ompletion of cause of
his cer Il direct	2	examiner? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident	No th 5 ☐ Pending investigatio	28a. Date (Mo	Inpatient 2 e of Injury nth, Day Year	28b. Ti	patient 3 Do	28c. Injury Work	r: 4 ☐ Nursing	Home 5 Resi	dence 6 🗆 (ify)
urs after death. srel Director: After t illed in by the funers I Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	build	ding, etc. (Sp	ecify)	m, street, factor			City or To	wn, State)		ral Route Number,
vithin 24 hou to the Fune ompletely fil	2000	29a. Certifier (Check only one) 29b. Signature and	2 ☐ Medicel Exe	miner: On the	ne best of my basis of exam nner stated.	knowledge, nination and	Vor investigation	at the tim n, in my op c. License	inion, death occ	e, and due to the curred at the time,	date and place 29d. Date sig	e, and due	to the cause(s)
3 – ŏ	-	1	ress of person who	secto completed cau	use of death (Item 23a) (Type, Print)		5936		coli		
3 State		1.01	4 V 13/0/1	100 (Garra Segistrar's Si	/ St gnature	Salish	un ,	MD 21	804			
Registrar	-		OCT 0 4	2004	Kolus	K.	Specke	•					

			1- State of Maryland / Departs Registrar Certification	ment of Health and M icate of Death		jiene	L 32870
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th	3. Time of Death
	Physici /Medio		EILEEN L. SENTELL			er 27, 2	2004 1:30 p ^M
	Examin	er		c. City, Town, or Location of Death		4c. County of	
	Eupovol		Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Laurel Under 1 Year If Under 24 Hrs.	8. Date of Birth		George's 9. Birthplace (State or Foreign
	Funeral Director			onths Days Hours Min.	April 27	, 1926	West Virginia
	pu 💃		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				
	faryla shov	ŭ		on			10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	the N 28e-1	Director	Maryland Prince George's Laurel	I Of. Zip Code	1	0g. Citizen of W	
	3a or	D	10114 High Ridge Road	20723		U.S.A.	
	death	Funeral		Decedent of Hispanic Origin? (Spiss, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race	- American Indian,
36	or it		1 Never Married 2 Married 1 Yes 2 No	Yes 2X No Specify:	rticari, etc./	Specify:	x, White, etc.
21215-0036	72 hours after death with the Maryland naturel; or items 23a or 28e-1 show dical Examiner must be notified at	Completed by	3	's Usual Occupation			White
15	nin 72 n na	plet	(Specify only highest grade completed) (Give kind	d of work done during most of work NOT use retired)	ing	16b. Kind of Bus	siness/industry
212	e filed within at Hygiene. I other then "vent, the Max	Com	Elementary/Secondary (0-12) College (1-4or 5+) Homemal	ker		Own Hom	ie
	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, I	Maiden Surname)
Z a	2 should be and Mental Is marked craumatic ever	70	Clem Crislip	Opal Sk			
Maryland	nd 2 shallth and 27 is n			ddress (Street and Number or Rura			
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heatth and Mental Hygiene. ortent: If item 27 is marked other then "naturel", or items 23a or 28e-1 show injury or other traumatic event, the Medical Examiner must be notified at 8.		Jacquie S. Sentell - Daughter 10114 I	n (Name of			ind 20/23 Dity or Town, State
E O	Pages nent of int: If it		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Fort Lincol	n Cemetery 10/2	2/2004	Brantwo	nd Maruland
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licensee 22. Na	ume and Address of Facility Gas	ch's Fur	neral Ho	me, P.A.
_	82 5 8 9			39 Baltimore Ave			e, MD 20781
þ	10.0		23a. Part1. Enter the disease, or complications that caused the death. 6 not enter the shock, or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac of	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Respiratory	tailure			10 MIN.
	Examiner		Due to (of as a consequence of):	1	1000		2 1 26 25
		Jer	Fedurantially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	iung Carc	noma		2 GEGO
	cuted nd ransit	Examiner	that initiated events C.	U			0
90	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,	cate b	by Physician/Medical	d				
Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date	of delivery
m	death e atte	iciai	in the past 12 months? 1 Vec 3 No. 4 Pregnant at time of death 5 Oth	opic pregnancy ner (specify)		Mont	/
P.O.	at the by the	hys	9 ☐ Unknown				
Ś	res th igned be de		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		_	oute to the cause of death?
Örc	w require been sig should b	eted					B ☐ Probably 4 ☑Unknown
Rec	has ge 2 (Completed			24a. Was ai autops perforn	y pri	ere autopsy findings available for to completion of cause of ath?
Division of Vital Record	Physicien: The la r this certificate has ral director, page 2	e Co	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2	X No	Yes 2 No
>	ysicie is cert direct	0 8	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3	Othor			(Specify)
0	Attending Physicien: or death. ector: After this certifice by the funeral director.	J: L	27. Manner of Death 1 S □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	d
Sio	ittendil death. stor: Ai	catle	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Ξ	I or Attending after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Sti City or Town	reet and Number , State)	or Rural Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occ	surred at the time, date and place a	and due to the ca	use(s) and man	por as stated
	ne Ho	edical	(Check only one) Medical Examiner: On the basis of examination and/or investigand manner stated.	gation, in my opinion, death occurre	ed at the time, da	ite and place, an	d due to the cause(s)
	To the within 2 To the complet	Š	29b. Signature and title of certifier	29c. License number	29	d. Date signed ((Month, Day, Year)
	1		Moxuel in	D35176		9	129/04
	W/5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	0 / /	Par	1 / 1	
	Sta	te.	Marcia L Will MD 7525 GEERWAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Y CEPTER OH-	UKEEN	pest	rh()
	Registr	3	OCT 0 1 2004 Security Signature				

			1 - For State Registrar	State of M	Marylan		artment rtificate			and M	ental Hyg	jiene	004	32880
	Dhyaiai		1. Decedent's Name (First, Middle	e, Last)	-						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic	100	Lucille Eller	n Smith							Octobe:		2004	6:00 A M
}	Examin	er	4a. Facility Name (If not institution	_					Location of	of Death			County of Death	1
			Nichol's She	Ltered Home	for E	Clderly		idgev					Harford	
	Funeral		5. Social Security Number	6. Sex 7. A		last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day Aug • 1	Year)	9. Birth	place (State or Foreign
	Director		213-16-9654		83	Yrs.					Aug. 1	/, 19	921 Mar	yland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					-		10d. Inside City Limits
	f sho	ō	100	c 7		7.1								1X Yes 2 □ No
	the t	Director	MD Hart	cora		ADE	erdeen					Og Citiz	en of What Cou	into/2
	with sa or	ā	309 Custis St	reet			101. 2.10	210	001				J.S.A.	nio y r
	ns 23	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13. V	Was Decede			ain? (Spe	cify Yes or No-	- , -	4. Race - Amer	ican Indian.
(0	r Iter	F.	1 Never Married 2 Marri				_			, Puerto I	cify Yes or No- Rican, etc.)		Black, White	, etc.
93	al'.o	by	3 ₩Widowed 4 Divorced	If Yes, Give Year or Date:	s:		1□ Yes 2	₩ No	Specify:				Specify: Whi	te
2-0	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Evarth at Front Le Italified at	Completed		t's Education st grade completed)		16a. Dece	dent's Usual kind of worl	l Occupa	ition	t of working	10	16b. Kin	d of Business/li	ndustry
2	within lene. than	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	DO NOT use	e retired,)	or working	'9			
2	e filed within al Hygiene. other than vant, tre Ma	Co	12	0		Home	emaker	<u> </u>					nome	
Ē	be fill d oth	Be	17. Father's Name (First, Middle,								(First, Middle, i Virgin			her
<u>\</u>	2 should be f and Mental H Is marked of raumatic ava	ို	Harry Clay Wa							-				
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 2 how item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic avant. It a Hygical Evaruhar mast be rediffed at		19a. Informant's Name/Relations								Route Number			
	of Health of Health item 27 I	1	William L. Sr	IIIII, UL.	20h P	lace of Dispo			1 2 30.					
altimore,	Pages nent of h int: If ite		1X Burial 2 ☐ Cremation		. 0	emetery, crer	natory or oti	her place		10/8			ation - City or T	
I iii	it. Parturbility		* 4 □ Donation 5 □ Other (S		St.	1			411			AU	erdeen,	М
Ba	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service	for 14 C/N	Hesb	e	Tarri Abero	ng-(Cargo	Fune	eral Hon 21001	ne, 1-33	99 ^A •	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death line.	n. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	disease or condition									Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or a	as consequ	uence of):								
		_	Sequentially list conditions,	b. Due to (or	as a consequ	ionoo afti								
	ted	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ	derica orj.								
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	C. Due to (or a	as a consequ	uence of):								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	al												
9	tificate ng phys as the	edlcal		0.										
Вох	eath certifi attending for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23	3d. Date of deliv	rery
-		icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant	at time of de		Ectopic pre Other (spe						Month	Day Year
P.O.	a So	hys	9 🗆 Unknown	9 Unknown							_			
	w requires that been signed to should be deta	by	Part II. Dther significant condition	ons contributing to death	but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	oacco us	e contribute to t	the cause of death?
ord	law requires as been sign 2 should be	ed									1 🗆 Ye	es 2.	No 3 ☐ Pro	bably 4 □Unknown
ecc	2 2 2	ple									24a. Was a			opsy findings available ompletion of cause of
of Vital Records,	The age	Completed									perform		death?	2□ No
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	Check on on	-		
Ž	s si	2	1 ☐ Yes 2 No	Hospital: 1 🗌 Inpa	itient 2	ER/Outpatien		100000	4 🔲 Nu	rsing Hom	ne 5 🗆 Reside	nce 6	Other (Speci	Wichols
n		on:	27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of Ir (Month, L	njury Da <i>y Year)</i>	28b. Time of Injury		c. Injury Work			8d. Describe ho	w injury	occurred	serior Home
Sic	Attending r death. actor: After by the fune	cat	2 Accident investig	not be			М		'es 2□N					
-	of the land	Certification:	4 Homicide determ	ined 286. Place of	Injury - At ho etc. <i>(Specif</i> y	me, farm, str	eet, factory,	office		2	8f. Location (St. City or Town	reet and n, State)	Number or Run	al Route Number,
	pital		29a. Certifier 1 Certifyin	g Physician: To the be	at of my know	wlodgo doeth				d alasa s				
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examinat	tion and/or inv	estigation,	in my op	inion, deat	d place, a th occurre	d at the time, da	ate and p	lace, and due t	o the cause(s)
	Vith To t	Σ	29b. Signature and title of certifie		der	MI	29c.	License	number	0/1	9 2	9d. Date	signed (Month,	Day, Year)
,	1		Ligina		non	- /-	\ \L	, 00	13	10	0	CR	ver a	, 200/
	φ		Stephani	who completed cause of	death (Item	90.	Z A	ver	-111	Rd	Jó	ppa	MA	21085
:5	Sta Registr	-	31. Date filed (Month, Day, Year)	6 2004 32. R	strar's Signal	The A	book	,						

State of Maryland / Department of Health and Mental Hygiene

1 -0220		
KG	1_	Fc St

Reg. No. 3. Time of Death

11:30 A^M

1X Yes 2 □ No

Approximate Interval Between Onset and Death

Year

Day

•		
Physicia	n	
/Medica	ıl,	
Examine	r	

Funeral

Director in than "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at othar than

within 72 hours after death with the Maryland Director Funeral Baltimore, Maryland 21215-0036 Completed by Be 2 should be finand Mental H permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or othar trat once. Physician /Medical Examiner Examiner The law requires that the death certificate be executed burial-transit attending physician and Division of Vital Records, P.O. Box 68760, Physician/Medical the ò à Completed page Attanding Physician: funeral director, Be Certification: To After the 1 after death Diractor: filled in by ŏ within 24 hours To the Funeral Medical

Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day September Michael D. Swann 27, 2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 2/4/91 9. Birthplace (State or Foreign Country) Washington DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1XM 2□F 13 577-21-2714 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20020 2645 Douglas Road SE #301 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DC Public Schools Elementary/Secondary (0-12) College (1-4or 5+) 7th Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pamela K. Swann Michael D. Gale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2645 Douglas Rd SE #301 SE Wash DC 20020 Pamela Swann / mother 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Harmony National ¹ 4 □ Donation 5 □ Other (Specify) 10/1/04 Landover, 21. Signature of Funeral Service Licensee 2BNank antiething Fartuneral Chapel Inc. 420 H Street NE Washington DC 20002 23a. Pert1. Enter the disease, or complications that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Immediate Cause (Final disease or condition resulting in death) the chest and left Gunshot wound to Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2

No 1 X Yes 2 □ No 26. Place of Death (Check only one)

25. Was case referred to medical kaminer' ¥¥Yes 2 No 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 X Homicide

1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 9-27-04

mil

m.D

Injury 10:50 A M

28b. Time of

1 ☐ Yes 2 💢 No 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In an apartment building. Southeast

28c. Injury at Work?

28d. Describe how injury occurred subject was shot 281. Location (Street and Number or Rural Route Number, City or Town, State) 2671 Doubles Place Southeast Washington DC

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

111 Penn Street, Baltimore, Maryland 21201

2 XMedicet Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) September 28, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hi

LING

31. Date filed (Month, Day, Year) OCT 0 4 2004



DHMH 17 Rev 1/2001

State

Registrar

			1 - For State Registrar	State of Mary			of Heal	th and Me	ental Hy	-	li 32882
	Physici /Medi		1. Decedent's Name (First, Middle, Las Helen Morgan	Scott				(2. Date of De Month	er Day 1 a	Year 10:50 A M
	Examir	er	4a. Facility Name (If not institution, give Doctor's Communit	,		4b. City, T Lanha		ition of Death		4c. County	of Death George's
В	Funeral Director		770 22 3303	7. Age (Ir □ M 2	yrs. last birthday) Yrs.	If Under 1 Months		nder 24 Hrs. 8 iurs Min. N	3. Date of Bir (Month_Da OV • 15 ,	th 1914 (9. Birthplace (State or Foreign Country). Columbia, SC
Prop/god/	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince Geo		c. City, Town or Lo Bowie	ocation					10d. Inside City Limits 1XXYes 2 □ No
is th	3a or 28 st be no	al Dire	10e. Street and Number 807 Jackson Valle	ey Court		10f. Zip C	ode 20721			10g. Citizen of V	What Country? 1 States
:1215-0036	pomin. Tago I have a sound Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it e Madical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Was Decede		ic Origin? (Spec oxican, Puerto Ri ecify:	ify Yes or No ican, etc.)	- 14. Race Blac Specify	e - American Indian, ck, White, etc. ': Black
21215-0036	ne. han "natu e Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed</i>) College (1-4or 5+)	(Give		Occupation done during retired)	most of working	7	16b. Kind of Bu	•
CA Z	n and Mental Hygiene. 7 is marked other than "r. raumatic event, it e Mad	To Be Cor	12th 17. Father's Name (First, Middle, Last) Mance Morgan		Print	er		Mother's Name (Federa]	
Maryland	ulth and M 27 Is mar r traumat	-	19a. Informant's Name/Relationship (7 Debbie Sanders/	ype, Print) Daughter				umber or Rural i		or, City or Town, wie, MD	
Baltimore,	Department of Health a Important: If item 27 is any injury or other training.		20a. Method of Disposition 1 Description 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State .	Pob. Place of Dispo cemetery, crem Ft. Linco	natory or oth	er place)	Da 10/8/2		20c. Location - Brentwood	City or Town, State
Balti	Departrum Imports any inju		21. Signature of Funeral Service Ricens	500	Fo	Name and	coln	Funeral	Home d Bron	twood, N	4D 20722
	hysician /Medical xaminer		23a. Part1. Emer the Isease, or comp shock, or heart fillure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the one cause on each line. a. Breast Due to (or as a co	CANCE	er the mode	of dying, suc	h as cardiac or	respiratory ar	rest,	Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co							
of Vital Records, P.O. Box 68760, Physician: The law requires that the clearly cardifficate he executed	signed by the attending physician and d be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	Fetal death 3	Ectopic preg				23d. Date Mon	e of delivery nth Day Year
Records, P.	been signed b	b	Part II. Dther significant conditions co	20 0 1	ot resulting in the un	nderlying cau	se given in F	Part I.	1 🗆 Y	es 2□No	ibute to the cause of death? 3 Probably 4 Junknown
al Re	certificate has birector, page 2 s	Completed	25. Was case referred to medical						1 ☐ Yes	med? de 1	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
on of Vital	After fune	tlon; To Be	examiner? 1 Yes 2 No 27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	2 ER/Outpatien 28b. Time of Injury		Othor	28	5 Resid	ne) lence 6 Othe low injury occurre		
Division To the Hospital or Attending	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, streepecify)				f. Location (S City or Tow	Street and Numbern, State)	er or Rural Route Number,
Hosoit	within 24 hours To the Funeral completely filled	Medical (29a. Certifying Phy (Check only one)	rsician: To the best of miner: On the basis of exa and manner stated.	y knowledge, death imination and/or inv	occurred at restigation, in	the time, dat my opinion,	te and place, and death occurred	d due to the d at the time, d	ause(s) and mar date and place, a	ner as stated. nd due to the cause(s)
Toth	withir To th comp	Me	29b. Signature and title of certifier	Mai AD			icense numb	ber 3275	2	_	(Month, Day, Year)
f_	4		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, I	Print)	5017	E 351	LAUR	er, Md	20107
8	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 4 2004	M.D. 575	Signature Special	W					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	Maryland.		artment of F					001	000	
			Decedent's Name (First, Middle, La	st)						2. Date of Death	g. No.	444	3. Time	of Death
	Physici /Medio		LESLIE G. SCHAFFE							Month 09	26	2004	5:30	
	Examin	er	4a. Fecility Name (If not institution, giv	street and number	or)		4b. City, Town, o	r Location o	of Death		4c. (County of Death		
			200 CHURCH STREET				MARDELA					WICOMI		
Ė	Funeral Director		5. Social Security Number 6. S 212-09-7682	ex 7.7	Age (In yrs. last 93	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, 12-22-19	Year) 910	9. Birth Cou BALT	plece (State intry) IMORE,	or Foreign
	p ,		Usual Residence of Decedent		140.00									
	aryla ehov	-	10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside (
	8a-f	Director	MD WICOMIC	0	MARDI	ELA S	PRINGS							s 2□No
	with the	급	10e. Street and Number				10f. Zip Code			10	g. Citiz	en of What Cou	ntry?	
	s 234	era	200 CHURCH STREET	10 111 - 5 - 1	.5	10.	2183					USA		
36	d within 72 hours after death with the Maryland glehe. If then "natural", or Items 23s or 28s-f show then "natural" or Items 12s or 28s-f show the Mardical Examining in the Learn-Life of a land of the market by the Mardical at the Mardical Examining at the market by the Mardical at the market by the Mardical Examining at the market by the Mardical Examining at the market by the Mardical Examining at the market by the Mardical Examining at the market by the Mardical Examining at the market by the Mardical Examining at the Mardical Ex	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Force: 1 Yes 25 If Yes, Give	s? No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Ori an, Mexican Specify:	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify:	etc.	
21215-0036	hour tural	ed to	3 Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates		Fa Dans	fant's Havel Ossus					V	HITE	
5		Completed	(Specify only highest gra	de completed)		(Give	ient's Usual Occup kind of work done o DO NOT use retired	during most	t of worki	ng 1	6b. Kin	d of Business/Ir	dustry	
72	within iene.	E O	Elementary/Secondary (0-12)	College (1-4o			RIVER	,			SIIS	LINE		
	e filed within at Hygiene. other than	a	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, M				
Maryland	should be nd Mental marked c	To B	GEORGE W. SCHAFFE	R				ANNIE	E ARM	TETTA				
ary	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailir	g Address (Street				City or	Town, State, Zii	Code)	
	C1 c2 20 1		RONNIE SCHAFFER -	SON			HURCH ST							3.7
Baltimore,	s 1 and st Health item 27 other tr		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place					ation - City or T		<i></i>
E	Page ent o nt: If ry or		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		.0	-	EM. CEMET	´ I	0_02	-200/ M/	DDE	TA CDDT	NCC MI	
Ħ	permit. Pages Department of I Importent: If It any injury or o	1	21. Signature of Funeral Service Licer		THREE		. Name and Addres							J.
ä	Depa Impo any ir		> Holling to	4 1600	un		05 EAST N							80 <i>/</i> i
	3,		23a. Part . Enter the disease, or comshock, or heart failure. List only	olications that caus	ed #1e death. D	o not ent	er the mode of dyin	g, such as	cardiac o	r respiratory arres	it,	, riaki DA	Approxima	te
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Chron	nic s	p-14	nuch	e l	un	1 disc		0	Interval Be Onset and	
	Examiner	-		Due to (or a	is a consequent	ce of):								
400		ē	Sequentially list conditions if any, leading to immediate	b. Due to (or a	is a consequenc	ce of):								
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
ó	cate be executed physician and the burial-transit	Ex	resulting in death) Last	Due to (or a	s a consequenc	ce of):								
8760,	te be ysicia ie bu	dical		d										
9	tifica ig ph as th	led												
Вох	death certific e attending p ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 D Fetal dea	ath 2	E				23	3d. Date of delive	ery	
	000	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of death		Ectopic pregnancy Other (specify)					Month	Day	Year
P. O.	that the de ed by the detached	hy	9 Unknown	9□ Unknown										
	The law requires that the the has been signed by thoage 2 should be detache	by F	Part II. Other significant conditions of	ontributing to death	but not resulting	g in the ur	derlying cause give	en in Part I.		23e. Did toba	cco us	e contribute to the	ne cause of	death?
ğ	w requir been si should I	ed								1 Yes	2 🗆	No 3 ☐ Prob	ably 4 🔲	Unknown
Records,	has be	Completed								24a. Was an		24b. Were auto	psy findings	available
Œ.	The rate har page	E						-		autopsy performe	a?	prior to co death? 1 \(\sum \) Yes	inpletion of a	ause of
Viital	ician: Th certificate ector, paç	Bec	25. Was case referred to medical					26. Place	of Death	(Check only one)	1 40	T Tes	212 110	
	% <u>∞</u> 5	Tof	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	tient 2 ER/	Outpatient	3□ DOA Othe	1.1-2.		ne 5 X Residen	ce 6	Other (Specifi	/)	
0	ng Ph ter thi		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of In	jury 28t	Time of	28c. Injury Work			8d. Describe how			·/	
<u>ō</u>	Attending ir death. ector: After by the fune	atic	2 ☐ Accident investigation		uy / 5di/	qury		res 2□N	10					
Division of	er de recto	Certification:	3 Suicide 6 Could not be determined	280. Place of Ir	njury - At home, etc. (Specify)	farm, stre	et, factory, office		2	8f. Location (Stre City or Town,	et and	Number or Rura	Route Num	ber,
٥	tal or A	Cer		Jan. 3, 1	oto: (opoony)					Only of Town,	Siale)			
	ospita hours uneral ly filled	cal	29a. Certifier 1 Certifying Ph	sicien: To the bes	t of my knowled	lge, death	occurred at the tim	e, date and	place, a	nd due to the cau	se(s) a	nd manner as st	ated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	one)	and manner s	or examination.	and/or inv	estigation, in my of	inion, deat	n occurre	at the time, date	and p	lace, and due to	the cause(s	;)
	To the within To the comple	Σ	29b. Signature and title of certifier				29c. License	number		29d	. Date	signed (Month,	Day, Year)	
			the Couls				000	705	570	9	120	3/04		
			30. Name and address of person who o	pmpleted cause of	death (Item 23a	a) (Type, F	Print)		. 1					
2				mo 1.	7 945	0:	vision	14.	Salli	Jbuns.	N	201218	YUY	
3	Stat	te	31. Date filed (Month, Day, Year) SFP 3 0 2	32. Regis	trar's Signature	1	1			71				

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State Registrar 0 5 2004

Mon

Edward F. Fisher

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/ 56 Thomas Johnson Dr./ Frederick, Maryland 21702

	1 ,		1 - For State Registrar		aryland / D	epartmen Certificat					ene)()4	3288	
	Physici	an	Decedent's Name (First, Middle, Last	,						. Date of Death Mogth	Day	Year	3. Time of De	ath
	/Media		Shadeareauna							C fober	Day 2	2004	2310	М
	Examir	er	4a Facility Name of not institution, give	m/- 1 1	1 1.1	4b. Gity,	Town, or	Location of	of Death	4	4c. Co	ounty of Deeth	٠.	
_			5. Social Security Number 6/8	PICEKS T	CSOTY & L	day If Under	1 Year	MOR If Under	24 Hrs 0	Ty				
	Funeral Director			_M 2 ⊠ F		rs. Months	Days	Hours 2	Min.	Date of Birth (Month, Day, Y	'ear)	9. Birth	place (State or Fo intry)	oreign
			Usual Residence of Decedent						U	CE. 2,	200	4 Ma	rÿland	
	ylan		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City L	imits
	e Ma	cto	Maryland Charl	es	Issue	9							1 ☐ Yes 2🕅	No
	ith th	Directo	10e. Street and Number			10f. Zip	Code			100	. Citizer	of What Cou	intry?	
	23a		16186 Rock Poin	t Rd.		20	0645				U.	S.A.		
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Exatti intrinial be indiffied at	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Was Deced If Yes, spec	dent of Hi	spanic Ori n, Mexicar	igin? (Specif	y Yes or No- an, etc.)	14.	Race - Ameri Black, White		
36	s afte	by Fi	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give	No	1 🗆 Yes				,	So	ecify: Bl		
8	hour tural		15. Decedent's Ed	Year or Dates:	160	Decedent's Usua	-1 0			1.40				
15	d within 72 ho jiene. r than "natur r be Med cal	Completed	(Specify only highest gra	de completed)		Give kind of world life. DO NDT us	rk done d	lurina mosi	t of working	16	b. Kind	of Business/Ir	ndustry	
12	igne.	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Baby		,						
ğ	il Hygi other	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (F	First, Middle, Ma	iden Su	тате)		
lar	uld by Menta Menta rrked	To B	James Sing Tho	mas				Jean	nelle	Moniq	ue	Clark		
Maryland 21215-0036	s 1 end 2 should be filed if Health and Mental Hyg item 27 is marked othe other traumatic svent,		19a. Informant's Name/Relationship (7	Type, Print) Mot	her 19b.	Mailing Address	(Street a	and Numbe	er or Rural R	oute Number, C	ity or To	wn, State, Zij	o Code)	
	end 2 n 27 in 27 ier tra		Jeanelle Moniqu	e Clark	Р.	O. Box					064	5		
ore	of Health of Health If item 27 or other to		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	20b. Place of I cemetery	Disposition (Nan , crematory or o	ne of ther place	Oct.	8,20	04 20		ion - City or T		
Ē	Pages ment of ant: If it ury or o		'4 □ Donation 5 □ Other (Specify		Shiloh	n Unite	ed M	lethc	odist	Churc				
Baltimore,	permit. Pages Department of I important: If it any injury or o		21. Signature of Funeral Service Licen	seg	M00668	Willi Willi	d Addres Lams	s of Facility Fun	ieral	Home, d., In	P.	А.	2064 d, Md.	10
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause	the death. Do no	ot enter the mod	e of dying	g, such as	cardiac or re	espiratory arrest	,	II IICa	Approximate	
	Physician		Immediate Cause (Final		Pma D	MINAR	11/1	h					Interval Between Onset and Deat	
	/Medical		disease or condition resulting in death)	aDue to (or as	a consequence of):	WY	1.1						
	Examiner		0	CONV	rical	Mun	We	enc	e.				5 Days	
	n =:	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	1						/~	<u>. </u>
	acute nd trans	Examine	that initiated events	c									•	
Ő,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):								
8760,		dical	•	d										
9	death certific e attending p ad for use as	Physician/Me	IF FEMALE:	220 If you system	4									
Вох	attendatten for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 Ectopic pro					23d.	Date of delive Month	ery Day Year	
	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	time or death	5 ☐ Other (sp	өспу)						,	
α_			Part II. Other significant conditions co	ontributing to death b	ut not resulting in t	the underlying ca	ause give	n in Part I.		23e. Did tobac	co use o	contribute to the	he cause of death	1?
Records,	requires een sign nould be	d by								1 🗆 Yes	2 Z N	o 3 Prob	abiy 4 🗆 Unkno	own
00	w requir been si should	iete								24a. Was an	2/	th Were auto	psy findings avail	lable
Re	The law rete has be page 2 sh	Completed								autopsy performe		prior to condeath?	mpletion of cause	of
		Ö	25. Was case referred to medical					OF Place	of Dooth C	1□ Yes 2/□ heck onlone	No	1 🗆 Yes	2□ No	_
	8 8 5	ToB	examiner?	Hospital:	ant 2 ☐ ER/Outp	patient 3 DO	A Othe	r		5 ☐ Residence	a 6 🗆	Other (Specif	iv)	
	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Tir	me of 28	Bc. Injury	at	_	Describe how				-
0	Attending r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y Yea <i>r)</i> Inji	M	Work	es 2 1	No					
Division	f or Atten efter deat Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At home, farn	n, street, factory	, office		28f.	Location (Stree City or Town, S	t and Nu	umber or Rura	I Route Number,	
	Italo rs eft ai Di	Ce								ony or rown, o	iaio		•	
	To the Hospital or Attenwithin 24 hours effer deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best liner: On the basis o and manner st	r examination and/	death occurred a or investigation,	at the time in my op	e, date and inion, deat	d place, and h occurred a	due to the caus it the time, date	e(s) and and plac	manner as si ce, and due to	tated. the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	-		29c.	License	number		29d.	Date sig	gned (Month,	Day, Year)	
}	1		Mymit	AD		AT	414	1357×	F	Ì	012	1200	4	
			30. Name and address of person who o	completed cause of d	eath (Item 23a) (T	ype, Print)	inb	cnly	B. F	=OR+NO	en	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	
			600 M.h	101/e SM	elt 1	Basti.	non	٠, /	many	Land		21287		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1		,	7					
	Registr	ar	OCT 1 5 2004	Denn	2	Span	EN							

DHMH 17 Rev 1/2001

			For 10 4 04	State of M	laryland / Dep			d Mental Hy	giene	
46	· •		1 State 10-4-04 Registrar Amen d # 1. Decedent's Name (First, Middle		er FHcr	rtificate d	of Death	2. Date of De	Reg. No. ()	3 2 8 8 6 3. Time of Death
81	Physici /Medi		Crescencio	Lasty	L.	Tan September			ber 30 2004	7:29 P. M
	Examir		4a. Facility Name (If not institution,	-)	4b. City, Town, or Location of Death			4c. County of Death	
			3016 Novak Te		ge (In yrs. last birthday		nsville Bar If Under 24 F	trs 8 Date of Ric	Montgom	
ı	Funeral Director	Н	611–10–5343	X 2□ F	:80 Yrs.	Months Da		in. 8. Date of Bir (Month, Da Dec. 1.	2 1923 Phil	place (State or Foreign htry) lipines
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				0d. Inside City Limits
	ith the Marylan or 28e-f show	tor	Maryland Montgo	mery	Burto	nsville	2			1 ☐ Yes 2 ☐ No
	or 284	Director	10e. Street and Number			10f. Zip Coo			10g. Citizen of What Cour	
	eath w	eral	3016 Novak Teri	12 Was Decedent	Ever in U.S. 13.	Was Decedent	20866	(Specify Ves or No	U.S.A.	an Indian
9	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show ha Medical Examiner must be notified at	by Funeral	1 Never Married 2 Marrie	Armed Forces	? No	If Yes, specify ((Specify Yes or No lerto Rican, etc.)		etc.
003	hours tural', al Era		3 Widowed 4 Divorced	Year or Dates:	WWII			Filipino		ipino
215	hin 72 9. an "na Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed)	(Give	dent's Usual Oc a <i>kind of work do</i> <i>DO NOT us</i> e re	cupation one during most of t tired)	vorking	16b. Kind of Business/Ind	Justry
21	filled wit Hygiene other tha		12	College (1-4or 2	Nava	1 Offic			Phillipine 1	Navy
and	d be fi	To Be	17. Father's Name (First, Middle, L Tan Muyco	ast)				lame (First, Middle, nina Laino		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. It mar 27 Is marked other than "natural", or itams 23a or 28e-f show other traumatic avant. The Medical Evantral must be notified at	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ng Address (Str			ar, City or Town, State, Zip	Code)
	ges 1 and 2 t of Health If itam 27 or other tra		Tess Valencia (Daughter)	301 20b. Place of Disp	6 Novak	Terrace	Burtons	ville, MD 208	
mor	8° = 5		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Pagasz C	matory`or other	place) 10-	- 9,04	20c. Location - City or To	
Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service L		Drimagnete	2. Name and Ad	Idress of Facility	Rendon/Ha	Pasay City, ale Funeral	Home
	205 20		nullan) ens					m, Maryland	
	Pnysician		23a. art1. Enter the disease, or of shock, or heart failure. List a mediate Cause (Final	nly one cause on each li		ter the mode of		4 4		Approximate Interval Between Onset and Death
	/Medical	1	disease or condition resulting in death)	a Due to (or as	a consequence of):	LLIN	LL	MYELO	MH	1 YEAR
k	Examiner	-	Sequentially list conditions,	b. Due to lor ee	a consequence of					
	uted d ansit	Examine	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence on					
30,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	icate b physic s the b	dical		d						
Box (death certificate be executed e attending physician and od for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		75			23d. Date of delive	ry
O. B	ne deat the att	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a		Ectopic pregna Other (specify)			Month	Day Year
<u>α</u>	The law requires that the de ate has been signed by the a bage 2 should be detached	by Ph	Part II. Other significant condition	s contributing to death b	out not resulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use contribute to th	e cause of death?
Vital Records,	w requires been sig should be							1 □ Y	es 2 No 3 Proba	ably 4 Unknown
3ec	The law rate has be page 2 sh	Completed						24a. Was a autop	sy prior to con	osy findings available apletion of cause of
tal		e Co	25. Was case referred to medical						2 No 1 ☐ Yes	2□ No
f Vi	nysici lis cer direc	To B	examiner?	Hospital:	ent 2 ER/Outpatie	nt 3 DOA	26. Place of L Other: 4 ☐ Nursing	eath <i>Check only of</i> Home 32 Resid	ne) lence 6 □Other (Specify	1)
0 00	ing After une		27. Manner of Death 1 Natural 5 ☐ Pending		y Year) 28b. Time o		njury at Vork?		ow injury occurred	
Division of	or Attanding after death. Diractor: After In by the fune	Certification;	2 Accident investigation of the could not determine t	ot be 28e. Place of Inj	jury - At home, farm, st		☐Yes 2☐No	28f. Location (S	treet and Number or Rural	Route Number.
Ö	i Pirite		4 Homicide determin	building, et	c. (Specify)			City or Tow	n, State)	,
	5 4 7 9	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis o and manner st	it examination and/or in	h occurred at the vestigation, in m	a time, date and pla y opinion, death oc	ce, and due to the courred at the time, co	cause(s) and manner as stated and place, and due to	ited. the cause(s)
ı	To tha I within 2. To the I	Me	29b. Signature and title of certifier	110			ense number		29d. Date signed (Month, D	Jay, Year)
0	6		30 Name and address of	the completed same of	looth (Ita- 20c) 7	Driet) /	10/7/5		104	11:40
K	(5)		30. Name and address of person w	EN KARA	WAN US	- PAAA	DI UKE	ENBELL ALL A	TO THE STATE OF TH	U *3
	Sta Registr	-47	31. Date filed (Month, Day, Year) OCT 0 1 20		rar's Signature	AR A	CUL 101	ALK A	40 20 740.	
	riegisti	uı	OCT 0 1 20	" NOTEN	The paper					

		State of Maryland / Department of Health and M Certificate of Death	•	ne
Physicia /Medic		Decedent's Name (First, Middle, Last) JOSEPH NORMAN TYLER	2. Date of Death	Day 2004 3. Time of Death 1418 M
Examine	er	4a. Facility Name (If not institution, give street and number) Memorial Hospital EASTON		4c. County of Death TALL
Funeral Director		5. Social Security Number 215-46-5934 Usual Residence of Decedent 6. Sex 1	8. Date of Birth (Month, Day, Ye SEPT. 20,	9. Birthplace (State or Foreign
Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location MD QUEEN ANNE'S CHESTER		10d. Inside City Limits 1 ☐ Yes 2 🏋 No
with the	I Direc	10e. Street and Number 10f. Zip Code 1624 SEWARD ROAD 21619		Citizen of What Country?
→ S 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	by Funeral Director	11. Marital Status 1		14. Race - American Indian, Black, White, etc. Specify: WHITE
1215-003 within 72 hours liene. Ithan "naturet, tre Neulsell Eve	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ring	. Kind of Business/Industry
○ □ 등호존의	To Be Co	12 ADMINISTRATIVE ASSISTAN 17. Father's Name (First, Middle, Last) NORMAN TYLER BARBARA	e (First, Middle, Maid	PFFICE den Sumame)
M M M M M M M M M M M M M M M M M M M		19a. Informant's Name/Relationship (Type, Print) ANNE KYLE TYLER/WIFE 19b. Mailing Address (Street and Number or Run 1624 SEWARD ROAD, CHES		ty or Town, State, Zip Code) 21619
		1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		Location - City or Town, State EVENSVILLE, MD
Baltimor permit. Pages Department of Importent: If its any injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN 106 SHAMROCK ROAD,		
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause en each line. Immediate Cause (Final disease or condition resulting in death) Due to (of as a consequence of):	or respiratory arrest,	Approximate Interval Between Onset and Death
8760, sate be executed by sician and the burial-transit.	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of):		
Vision of Vital Records, P.O. Box 68760, Attending Physiclen: The law requires that the death certificate be executed refeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
Cords, P	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	/	o use contribute to the cause of death? 2 \(\sum No \) 3 \(\sum Probably \) 4 \(\sum Unknown \)
Division of Vital Records, to Attending Physicien: The law requires to after death. Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Completed		24a. Was an autopsy performed?	
of Vita Physiclen: this certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		6 □Other (Specify)
ision o' trending Ph death. ctor: After th	atlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of 28c. Injury at Work? 4 Injury 4 Work? 4 Injury 4 Work? 4 Injury	28d. Describe how in	
	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
To the Hospitel or within 24 hours after to the Funerel Discompletely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
To the within To the comp	Σ	29b. Signature and title of cediffer 29c. License number 057857	29d. D	Date signed (Mgnth, Day, Year)
IOKK		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID H. SMITH M.D., 29466 PINTAIL DRIVE, SUITE 5, EAS	TON, MD 2	21601
State Registra		31. Date filed (Month, Day, Year) SEP 2 1 2004		

State Registrar Date filed (Month, Day, Year)
SEP 3 0 2004

ATRICIA

ame and address of person who completed cause of reath

32. Registrar's Signature

rocker

111 Penn Street, Baltimore, Maryland 21201

		1 - For AMEND #2	State of M OdperMD9/30/04,IC	Maryland / Dep GMCO <i>Ce</i>	artment of He			ene	00000
		Decedent's Name (First, M.	iddle, Last)				2. Date of Death	C 11 11 11	3. Time of Death
Physi /Med		Mary	Veronica	Whitesi	đe		Month Septembe	Day Year 18. 20	0 20 M
Exam		4a. Facility Name (If not instit	ution, give street and number		4b. City, Town, or Lo	ocation of Death	лересшре	4c. County of D	
			General Hospi		01ney			Montgo	mery
Funera Directo		5. Social Security Number 032-3(0-527)	1 1 1 1 25	ge (In yrs. last birthday) Yrs.		Hours Min.	3. Date of Birth (Month, Day, Y	ear) 9. E	Birthplace (State or Foreign Country)
		Usual Residence of Deceden		89			04/04/19	75 Ma	ssachusetts
yland		10a. State 10b. Cou	inty	10c. City, Town or La	ocation				10d. Inside City Limits
e Mar	ctor	Maryland Mo	ntgomery	Silver Sp	rino				1 ☐ Yes 2X No
or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
Z1Z15-0036 4 within 72 hours after death with the Maryland piene. r then "naturel", or Iteme 23e or 28e-f show the Marylest Examplest Trust be notified at	rai	14621 Stonewa			20905	•		IISA	
er de Item	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	Was Decedent of Hispa If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
It's aff	by F	1 Never Married 2 I	If Yes Give		1 ☐ Yes XXNo	Specify:		Specify: W	hite
5-00 72 hou natura	ted	15. Dece	dent's Education	16a. Dece	dent's Usual Occupation		16	b. Kind of Busine	ss/Industry
within 7 ene.	Completed		ghest grade completed) 2) College (1-4or	life.	kind of work done duri DO NOT use retired)	ing most of working			,
Maryland 21215-0036 d2 should be filed within 72 hours aff th and Mental hygiene. It a marked other then "netural", or treumatic event, the Medical Exami	Son	Elementary/Secondary (0-1	-,		memaker			Own He	ome
be filed tall Hygie dother event.	Be	17. Father's Name (First, Mide				3. Mother's Name (_	
should by and Menta marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked imatic events of the marked image.	P	Alexander Fi				argaret V	<u>_</u>		
Mar 12 sh 12 sh 7 sh re un	0	19a. Informant's Name/Relati	_		ng Address (Street and				
the lear		Leonard J. Wi	iteside / Sor	20b. Place of Dispo	1 Stonewal]	l Drive S	ilver_Sp	ring,MO	20905
or sages		1 x urial 2 ☐ Cremati	on 3 Removal from State	cemetery, crei	matory or other place)		200	. Location - City	
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item:		` 4 □Donation 5 □ Othe	· i / /		COVE Cemete 2. Name and Address of				assachusetts
Baltimory permit. Pages : Department of the Important: If ite any Injury or of	X	Jane	Memo	me :	11800 New H	Hampshire	Ave Sil	ver Spri	ing,MD 20904
		23a. Part1. Enter the disease shock, or heart failure.					espiratory arrest,		Approximate Interval Between
Enysicia	_	Immediate Cause (Final disease or condition	a. (1)	neumoni	0				Onset and Death
/Medica Examine	_	resulting in death)	Due to (or as	Neumoni s a consequence of:	= 0 .00	. 1 .			
	e e	Sequentially list conditions,	b. Due to (or as	s a consequence of):	T'E M'EL	ann			
ted	nin.	Sequentially list conditions, if any, leading to immediate cause. Enter United Sequences (Disease or injury)	A Due to (of as	s a consequence or).					
execu	Examin	that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):					
ob / bu, licate be executed physician and s the burial-transit	dicai		d ====						
od ifficate g phy as the	edic	1	0.						
Geath certific e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		35			23d. Date of d	elivery
. 0 00	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	2 □Fetal death 3 □ at time of death 5 □	JEctopic pregnancy Other (specify)			Month	Day Year
at the d d by the etached	Phys	9 Unknown							
	b	Part II. Other significant cond	litions contributing to death.	but not resulting in the u	nderlying cause given in	n Part I.			to the cause of death?
w requir	ted	701	rive your	Tag any			1 ☐ Yes	2 No 3	Probably 4 Unknown
HECOLOS, he taw requires t e has been signe age 2 should be	Completed	grum	C obstance	tive pu	manany	Mense	24a. Was an autopsy	prior to	autopsy findings available completion of cause of
					0		performed		s 2 No
OI VITAL Physiclen: This certifical ral director, p	Be	25. Was case referred to med examiner?	Hospital:		Other	6. Place of Death (0			
P P C	1. To	1 ☐ Yes 25 No 27. Manner of Feath	1 Inpati 28a. Oate of Inju		t 3 DOA Other:	4 Nursing Home	5 Residence		ecify)
offing Ph th. After this funeral	tion	1 Natural 5 ☐ Per		ay Year) Injury	Work?	2 🗆 No	i. Describe now ii	njury occurred	
LIVISION I or Attending after death. Director: After tin by the fune	ifica	3 ☐ Suicide 6 ☐ Cou	ild not be 28e. Place of In	jury - At home, farm, stre			. Location (Street	and Number or F	Rural Route Number.
in the s	Certification;	4 Homicide	building, e	tc. (Specify)			City or Town, Si	'ate)	
To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier Certification (Check only 2 Medic	ying Physicien: To the best	of my knowledge, death	occurred at the time, o	date and place, and	due to the cause	e(s) and manner a	is stated.
the H in 24 in 24 in 8 Fu	edical	one)	and manner st	of examination and/or inv	restigation, in my opinio	on, death occurred	at the time, date.	and place, and du ptember 18	ie to the cause(s)
To t Com	Σ	29b. Signature and title of cert	ifier	NIO	29c. License nu	imber O C		Date signed (Mer	
M		▶ Wilk	man 3	· Ivinale	7 7 42	285	7	ugun	15,0004
()		30 Name and address of pers	on who completed cause of o	death (Item 23a) (Type,	0 - 1 1	Н 110	. 0 -	7	
9		31. Date filed (Month, Day, Ye	va, 544	University	Blud	かりる	si wer	spring,	Ma 2090/
S Regis	tate trar	SEP S	10000	rar's Signature	Spark				

			State of Maryland / Department of Healt		ental Hygie	ene	
0		W	1 - State Registrar Certificate of Dea 1. Decedent's Name (First, Middle, Last)	alli	Rag. 2. Date of Death	No.	3. Time of Death
	Physici /Medic		Helen W. West		OCTOBER	^{Day} 200	
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local	ation of Death		4c. County of De	ath
		uit 4s	Berlin Nursing & Rehabilitation Ctr. Berlin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Ur	Inder 24 Hrs.	8. Date of Birth	Worces	
	Funeral Director			ours Min.	Month, Day, Yes	ear) (irthplace (State or Foreign Country) st Virginia
	put		Usual Residence of Decedent		Jepti 3,1	JII _ IFC.	
	Maryla f sho	5					10d. Inside City Limits 1XYes 2 ☐ No
	r 28a-	Director	MD Worcester Berlin 10e. Street and Number 10f. Zip Code		10g.	Citizen of What (
	th with		9715 Healthway Drive 21811		Ű		,
21215-0036	be filed within 72 hours after death with the Maryland nia! Hygiene. so other then "natural", or flems 23c or 28a-f show event, the Medical Evarrier must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Ves 2 No If Yes, Give Year or Dates: 13. Was Decedent ever in U.S. 13. Was Decedent of Hispania If Yes, specify Cuban, Median New Year or Dates:	ic Origin? (Spe exican, Puerto F ecify:	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: Wh	ite, etc.
5-0	72 hc natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during	most of workin	165	o. Kind of Busines	s/Industry
121	e filed within at Hygiene. Other then "	Juno	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)				
id 2	il Hygid other	0	T Joinemaker	Mother's Name	(First, Middle, Mai	Own Hom den Sumame)	1e
ylar	2 should be and Mental is marked o	To B	Chester Wright C	Catherin	e Long		. ^
Maryland	and and sum		19a. Informant's Name/Relationship (Type, Print) Kay Downs 19b. Mailing Address (Street and Number 19b. Mailing Address (Str				
	s 1 and 2 if Health item 27 other tra		20a. Method of Disposition 20b. Place of Disposition (Name of	- 141		Location - City of	
altimore,	Pages nent of nnt: If i		1 反 Burial 2 □ Cremation 3 □ Removal from State 1 ☑ Donation 5 □ Other (Specify) Creenlawn Mem. Park	c			ews, VA
Balt	permit. Pages Department of t Importent: If ite any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of F	acility The	Burbage	e Funera	
	4		1 Lucqueline 7 Master 108 William S	it., Bei	rlin, Md.	21811	Approximate
	Physician :		3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or hear failure. List only one cause on each line. Immediate Cause (Final	or as cardiac or	respiratory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a Due to (or as a consequence of):				I week.
	Examiner	L.	Sequentially list conditions, b.				
	utad 1 Insit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause. [Disease or injury				
oʻ	an and rial-tra	Exa	that initiated events c. The sulting in death) Last Due to (or as a consequence of):		-		
68760,	licate be executad physician and s the burial-transit	edical	d				
		/Mec	IF FEMALE: 23b Was decedent account. 23c If yes, outcome of pregnancy				
Вох	The law raquires that the death certif ite has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	olivery Day Year
P.O.	at the diby the	hys	9 Unknown				
	w raquires that s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Proceedings of the Control of	Part I.		/	o the cause of death?
Vital Records,	v raqui been should	Completed	desired as the second was the	2080	1 🗆 Yes	2 1 No 3 P	robably 4 Unknown
Re	he lav e has age 2	дшс	bladder cancer		24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
ta		0	25. Was case referred to medical	Place of Death	1 Yes 2 - (Check only one)	1 ☐ Ye	s 2 4NO
	Physic this ce al direc	To B	Hospital:		e 5 🗆 Residence	6 ☐Other (Spe	ecify)
Division of	Attending Physicien: The ri death. ri death. ector: After this certificate hiby the funeral director, page	Certification;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?		3d. Describe how in	njury occurred	
<u>/isi</u>	# 00>	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm, street, factory, office		If. Location (Street	and Number or B	ural Route Number,
5	s after al Direct	Serti	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)	arar riobie Namber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, and death occurred	d due to the cause d at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
١	To T Com	Σ	29b. Signature and title of certifier 29c. License numb	ber (DE) 29d. [Date signed (Mon.	th, Dey, Year)
f			* Kristine Steppen, no C1-000		DE) 29d. [
E:	TI		30. Name and address of person who completed suse of death (Item 23a) (Type, Print) KRISTNE GRIFFIN, UD 1209 CEASTING HIGHER 31. Date filed (Month, Day, Year) 32. Posistrar's Signature	AU FE	enuice:	TSLAND	DE 19944
	Sta		31. Date filed (Month, Day, Year) 32. Pagistrar's Signature				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
27	Registra	ař	OCT 0 4 2004 Marin D. 100000				

FT.

Certificate of Death

4b. City. Town, or Location of Death

WASHINGTON

State of Maryland / Department of Health and Mental Hygiene 3. Time of Death Year September 26 2004 6:58 A^M 4c. County of Death PRINCE GEORGE'S Birthplace (State or Foreign Country) North Carolina 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc.

Black

Private

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20c. Location - City or Town, State Brentwood, Maryland

2. Date of Death

22. Name and Address of Facility J. B. Jenkins Funeral Home

7474 Landover Road Landover, Maryland 20785 Approximate

Interval Between Onset and Death

23d. Date of delivery

Specify:

Year

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0043427 0 4.0 K. Eun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Irving Street N. W. Washington, DC 20010 Eric DeJonge M.D.

State Registrar

Medical

29b. Signature and title of certifier

1 - For State Registre

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

BEATRICE

C.

4a. Facility Name (If not institution, give street and number)

FT. WASHINGTON HOSPITAL CENTER

WHITAKER

31. Date filed (Month, Day, Year) 32. Registrar's Signature 0 1 2004

DHMH 17 Rev 1/2001

		State of Maryland / Department of Hea Certificate of De	oth	giene Reg. No⊋ ([] 229022
		1. Decedent's Name (First, Middle, Last)	2. Date of De	ath 3. Time of Death
	Physiciar /Medica	Bernard Chester Willett	Sept	27, 2004 2:45PM
	Examine	4a Facility Name (If not institution, give street and number) 4b. C	City, Town, or Location of Death	, , , , , , , , , , , , , , , , , , , ,
			LaPlata	Charles
	Funeral Director		Under 24 Hrs. 8 Date of Bin flours Min. (Month, Da Feb. 12	9. Birthplace (State or Foreign Country) 2,1922 Maryland
	42	Usual Residence of Decedent		
	show	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the M	Maryland Charles Nanjemoy		
	with	106. Street and Number 10f. Zip Code		10g. Citizen of What Country? U.S.A.
	death with the Meryland ms 23a or 28a-f show Linual be redified at	8225 Jacksontown Road 20662 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar		
020	aftar	L 1 □ Never Married 2 □ Married 1 □ Yes 227 î No	nic Origin? (Specify Yes or No lexican, Puerto Rican, etc.) pecify:	Black, White, etc. Specify: White
5-0020	72 hou		1	16b. Kind of Business/Industry
215	hin 7	(Specify only highest grade completed) (Give kind of work done durin Iffe. DO NOT use retired	g most of working	
2	od wit	6 Painter		U.S. Government
Maryland	De fil	17. Father's Name (First, Middle, Last)	. Mother's Name (First, Middle,	
3	Men Men Marke		Katie V. Mac	
Mai	12 st h end fla m traum	19a. Informant's Name/Relationship (<i>Type, Print</i>) Luke M. Willett Son 6795 Mason Sp		LaPlata, Md.20646
é é	1 en Healt em 2			20c. Location - City or Town, State
Baltimor	ant of th: If It	20a. Method of Disposition Disposition State	ct.2,2004 Gardens	Waldorf, Maryland
=	permit. Pag Depertment Important: I any Injury o		Facility uneral Home	
m	pemit. Deperti	M00668 4270 HAwth	orne Rd., In	ndian Head, Md.
68760,	physicial streets the burners	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Heart f	Onset and Death
Box	death certif	d		
Division of Vital Records, P.O.	of the de de by the latached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in pulmonary Hypertensian, Conference, Belateral pulmon, Chemia, Hyperthype	prilmorale 10	Yes 2 No 3 No Probably 4 Unknown an autopsy med? 24b. Were autopsy findings available prior to completion of cause of death?
a	certificate ha	of there or , comea) to firming	10)	
Ζï	Physician: this certific ral diractor,	examiner?	i. Place of Death (Check only o	
on of	fe fe fe	Testingation: 2 Produpation: 3 DOA	4 Nursing Home 5 Residence 128d. Describe h	how injury occurred
Divisi	To the Hospital or Attending within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funeral Director.	27. Manner of Death 1 BNatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Permined 28c. Injury at Work? 1 Permined 28c. Injury at Work? 1 Permined 28c. Injury at Work? 1 Permined 28c. Injury at Work? 1 Permined		Street and Number or Rural Route Number, wn, State)
	he Hospita in 24 hours he Funera pletely fille	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, description of the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, and due to the on, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the To the Committee of the Committee	29b. Signature and title of certifier 29c. License nur	wher 78370	29d. Date signed (Month, Day, Year) Sept. 27, 2004
	BB5	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul E Pritchett, MD II8 LaGrange Ave I	LaPlata, MD	20646
	State Registra	CED V A 2001 - Account A Magazin		

DHMH 16 Rev 6/95

	I Carcar D	T.	1- State of Maryland / Department of State of Maryland / Department of Certificate		ental Hygie	2001	32893																		
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last) One of the control of th		2. Date of Death Month	Day Year (200	3. Time of Death 7:024M																		
	Examir Funeral	er	NORTH ARUNDEL HOSPITAL BIE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	wn, or Location of Death WBURN/E Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	4c. County of Death AACOUN 9. Birth	place (State or Foreign																		
	Director		1 X M 2 F 40 Yrs. Months D Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		July 6 1	964 Mar	ntry) / land 10d. Inside City Limits																		
	death with the Maryland me 23e or 28e-f show finust be mulfited at	Irector	Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Co	ode	10g.	Citizen of What Cou	1 ĀYes 2 □ No																		
"0	ifter death wil r Itama 23a c	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Never Married 2 ☐ Married 1 ☐ Yes ②☐ No	113 It of Hispanic Origin? (Sper Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.																		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked to the than "naturel", or Itema 23a or 28a-f show is marked to the than "naturel", or Itema and the mailtier at aumatic event, the Madical Examiner must be mailtied at	To Be Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual C	done during most of working	ng 16b	Specify: B1a																			
nd 212			College (1-4or 5+) College (1-4or 5+) Truck	18. Mother's Name	(First, Middle, Maid		Contractor																		
Aaryla				Eva Han	l Route Number, Ci		•																		
Baltimore, I	permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 Is marka any injury or othar traumatic once.		Eva Wilson (Mother) 20a. Method of Disposition 1%CSurial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 1307 Farra 20b. Place of Disposition (Name cometery, crematory or othe St. John's Uther Church Cemete.	ara Drive (ate 200	Location - City or T	own, State																		
Baltin	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensee 22. Name and A	ery 9/30/ Address of Facility ese & Sons st St. Anna		denton, Md. 214																			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):																						
8760,	Hysician: The law requires that the death certificate has been signed by the attending at director, page 2 should be detached for use as	To Be Completed by Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Physician/Medical Ex	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dua to (ar as a consequence of): c. Due to (or as a consequence of):				
.O. Box 6																					IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregrant at time of death 5 Other (specific pregnancy) 1 Unknown			23d. Date of deliv Month	ery Day Year
Records, P																						Part II. Other significant conditions contributing to death but not resulting in the underlying caus	e given in Part I.	23e. Did tobacc	co use contribute to t
al Reco					24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available impletion of cause of 2 No																		
ion of Vital			To B	To B	To B	To B	ToB	ToB	To B	ToB	ToB	To B	ToB				6 □Other (Special	ýy)							
Division			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)		City or Town, St	•																			
			29a. Certifier (Check only one) 1. Certifier (Check only one) 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
	F3F8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	32567	250.	9-29-	0+																		
	Sta	te	2200 Defense ItWU Ste 20 31. Date tied (Month, De Bar) 9 2004 32. Resurar's Signature &	o crof	ton 1	1021	114																		
	Registr		The same of the sa	Z																					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year GLENDA EDNA MAE HEMSLEY WASHINGTON SEPTEMBER 29. 2004 11:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LA PLATA CENTER-GENESIS ELDERCARE LA PLATA CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
APRIL 2, 1910 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1 M 2 XF 94 220-28-2784 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits wat he notified at 1XYes 2 □ No MARYLAND CHARLES NEWBURG Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 12775 SHILOH CHURCH ROAD 238 20664 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examinary Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ŏ 1□Yes 2X No Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11TH GRADE COOK FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental is marked LEANA HEMSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i THOMAS WASHINGTON / SON 12775 SHILOH CHURCH ROAD, NEWBURG, MARYLAND 20664 20a. Method of Disposition

1 Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent; If it any injury or o SHILOH CHURCH CEMETERY 10/04/2004 NEWBURG, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Strature of Funeral Service Livenshe THORNTON FUNERAL HOME, P.A. LIDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTENTILE HEART Physician PRI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be executed burial-transit nding physician and use as the burial-train resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No P.0. 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à MEILITHIG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Sinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital After this certification funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 30 2004 D44436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

Some It Species

102

0 1 2004

32. Registrar's Signature

Paul Mellen C+ #102 Walderf Md 20602

		for State	State of Maryland /		Health and M	lental Hygie	ene	00000	
		Registrar 1. Decedent's Name (First, Middle, La.	-41	Certificate of	Dealii	Reg	. No.	14070	
Physici /Medic		Jo Anne V	•			2. Date of Death Month September	Day Year 27 2004	3. Time of Death 5:31 P	
Examir	ner	4a. Fecility Name (If not institution, give	e street and number)	4b. City, Town,	or Location of Death	-	4c. County of Death		
		Southern Maryla			Linton		Prince (
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last bi ☐ M 2☐XF 55	rthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	ear) 9. Birthp	lace (State or Foreign	
Director		578-68-6482 Usual Residence of Decedent		113.		Dec. 19,	1948 Was	h., DC	
faryland show		10a. State 10b. County	10c. City, Tow	m or Location			1	0d. Inside City Limits	
Man,	Ď	Maryland Prince	George's	Ft. Wash	nington			1 ∏ Yes 2 □ No	
death with the Maryland tims 23a or 28a-f show	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Coun	itry?	
23a c	a. D	3908 Pats Cour	t		20744		United S	tates	
ams ams	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Oecedent of If Yes, specify Cub		ecify Yes or No-	14. Race - Americ Black, White,	an Indian,	
(36) Don'th the Maryla burs after death with the Maryla reli, or Itams 23a or 288-f show Eranine Inditional at	by Funeral	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No		, 5,5,7			
	q p	3 Widowed 4 Divorced	L	71				ack	
5 to 15 min	lete	15. Decedent's Ed (Specify only highest gra	de completed)	 Decedent's Usual Occu (Give kind of work done life. DO NOT use retire 	pation during most of worki	ing 16	b. Kind of Business/Ind	dustry	
d 212-	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ince George			Dublic	Schools	
be filed y other, it want, it	Be C	17. Father's Name (First, Middle, Last)		ince deorge		(First, Middle, Mai		SCHOOLS	
land life file femal Hy kan oth	To B	Joseph Yag	er			Thelma F	au1kner		
larylan 2 should be and Mental Is marked of	-	19a. Informant's Name/Relationship (Type, Print) 19t	o. Mailing Address (Street				Code)	
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Willis J. Wilson	JrHusband	3908 Pats	Ct., Ft.	Wash., MD	20744		
19-27- Baltimore, permit. Pages 1 at Obepartment of Hea Important: If item any injury or othal once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	cometa	of Disposition (Name of ory, crematory or other pla	ice)	Date 200	c. Location - City or To	wn, State	
, Francis Para		'4 Donation 5 Dother (Specifi		ln Memorial	,		Suitland,		
Balti Balti Pepartr Imports any inju		21. Signature of Funeral Service Licen	1500 A + 111	22. Name and Addre			neral Home		
0 = 40389	_	John I.	Stewary II		-		sh., DC 20	019	
Physician		23a. Part1. Leter the disease, or composhock, in heart failure. List only immediate Couse (Final disease or condition	one cause on each line.					Approximate Interval Between Onset and Death	
/Medical		resulting in death)	a	of):		. 1	u	Mnow	
Examiner		Sequentially list conditions.	b. minlet	ph yes	tel 3 Ki	a where	, a	-14nown	
sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a consequence	ி):					
760, te be executed ysician and te burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a consequence	of):					
760, te be exe ysician a	cai E			0.,.					
687 fficate g phys	edic			_					
	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of deliver	v	
Geatte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fetal death 4☐Pregnant at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			Day Year	
o.0 at the by th	hys	9 Unknown	9□ Unknown			-			
ords, P.O. requires that the een signed by the hould be detached.	Completed by Physician/Medi	Part II. Other significant conditions of		n the underlying cause given	ven in Part I.		co use contribute to the		
ord ord oen s	ted	Santoidosis				1 Tes	2 □ No 3 □ Proba	ably 4 Dunknown	
ec ecs has b	npie	polymyosi	lis			24a. Was an autopsy	prior to com	sy findings available inpletion of cause of	
al Fine icate						performed		2□ No	
of Vital Of Vital Physician: T	Be	25. Was case referred to medical examiner?	Hospital:	structions of DOA Ott	26. Place of Death				
of of Physics rathis and did	1: To	1 Yes 2 No	28a. Date of Injury 28b.	ilpatient 3 DOA	4 U Nursing Hon	ne 5 🗌 Residence 28d. Describe how i	6 ☐Other (Specify,)	
Vision Vision Attending r death. sector: After	tior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	njury Wo	rk? Yes 2. □No		mary coodings		
Division or Attending after death. Diractor: After lin by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of injury - At nome, ra	irm, street, factory, office	2		and Number or Rural	Route Number,	
Div safte	Certification:	4 ☐ Homicide building, etc. (Specify) City or Town, State)							
Division of Vital Records, P.O. Box nother Hospital or Attending Physician: The law requires that the death certaint 24 hours after death. The law requires that the death cert or the transful prector. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best of my knowledge niner: On the basis of examination an and manner stated.	e, death occurred at the tild d/or investigation, in my d	me, date and place, a ppinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to	ited. the cause(s)	
						29d. Date signed (Month, Day, Year)			
		1 Horale	low		454		ptin Bes,	28104	
(1 (10)			completed cause of death (Item 23a)		astoo Yazo	dani, M.D.			
4	•	31. Date filed (Month, Day, Year)	32 Registrar's Signature	41- 5,146	Spain	40 5006 C	٥2		
Sta Registr		OCT 04 200		Coole					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State											
			Registrar 1. Decedent's Name (First, Middle, Last)				Dealli	2. Date of Deat	g. N62	3. Time of Death	
	Physici		Thomas Frederick						4 2004 Year	4:19 A M	
	/Medic Examir		4a. Facility Name (If not institution, give	street and numbe	r)	4b. City, Town,	or Location of Dea		4c. County of Death		
			Montgomery Hospice	Casey H	ouse	Rockvi	11e		Montgome	ry	
	Funeral Director		217-32-3713	7. A 2 ☐ F	Age (In yrs. last birthd 67 yrs	Months Days			Year) 9. Birth Cou 1937 Mary	place (State or Foreign intry) yland	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits	
Mar	Marylan -f show led at	to	Maryland Montgom	erv	T.	oolesvill	Δ.			1 ☐ Yes 21⊠No	
	r 28e	irec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							intry?	
	th witi	alD	18501 Whites Ferr	y Road		208	37		United St	ates	
	be filed within 72 hours after death with the Maryland that Hyglene. od other then "neturel", or items 23e or 28e-f show event, the Medical Examble it ust be multilled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 XXVidowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	3? 3No	3. Was Decedent of If Yes, specify Cult	ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White Specify: Wh		
	thour sture	To Be Completed b	15. Decedent's Edu	Year or Dates		cedent's Usual Occu	nation		6b. Kind of Business/Ir		
	within 72 ane. then "ne		(Specify only highest grad	College (1-40	r 5+) (G	ive kind of work done B. DO NOT use retire	during most of wo	rking			
	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, Ire M.		17. Father's Name (First, Middle, Last)		Mac	hinist	18. Mother's Na	me (First, Middle, M		<u>Fabrication</u>	
	Mental Marked of		Ward Werking				Ella Ro	llison			
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (T)	pe, Print)	19b. M	ailing Address (Stree	t and Number or R	ural Route Number,	City or Town, State, Zij	o Code)	
	コニトラ		Carol Bowen / Dau	ghter			Ferry Ro		ville, MD		
ore	0 0 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from Stat		sposition (Name of crematory or other pla	Octo	ber 6,	0c. Location - City or T	own, State	
Baltimore,	permit. Pag Department Importent: any injury o		' 4 □ Donation 5 □ Other (Specify)	20		en Mem. Ga		2004 F	rederick,	Maryland	
Ba	Deperment of the popular of the popu		21. Signature Funeral Frace Lice see Resthaven Funeral Services, Skkot Cody 9501 Catoctin Mtn. Hwy. Frederick, MD 2								
	Physician /Medical Examiner	il Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List party one cause on each line. Approximate Interval Between								
			Immediate Cause (Final disease or condition resulting in death)		ed Lung Ca	ncer				Onset and Death	
				Due to (or a	s a consequence of):						
			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	icate be executed physician and s the burial-transit		cause. Enter Underlying Cause Cleases of Irig y that initiated events c								
90,			resulting in death) Last Due to (or as a consequence of):								
68760,	physic the b	dicai		l							
.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death	3□Ectopic pregnanc 5□ Other (specify)	Sy .		23d. Date of delive Month	ery Day Year	
<u>α</u>	that the		Part II. Other significant conditions con	tributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to the	he cause of death?	
ords	w requires been sign should be	Completed by						1 🗆 Yes	2 □No 3K Prob	pably 4 Unknown	
Il Records,	fing Physicien: After this certifica funeral director, p							24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of 2 No	
Vital		Be	25. Was case referred to medical examiner?	ospital:			han	ath Check on one			
of		: To	1 ☐ Yes 2XXNo	28a. Date of In	ury 28b. Time	IBIL 3 DOA		lome 5 Resident	ce 6 XXOther (Specify injury occurred	y) Hospice	
ivision		Medical Certification:	1 XX Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year) Injur	y Wo	rk?]Yes 2□No	200. 2000.100 110	mary cocurred		
	or Attending after death. Director: Atte		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of la building, e	njury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	I Route Number,	
	To the Hospitel of within 24 hours at To the Funerel D completely filled in		29a. Certifier 1 Certifying Physical Check only 2 Medical Examinate	sician: To the bes ner: On the basis and manner s	of examination and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	, and due to the cau irred at the time, dat	se(s) and manner as s e and place, and due to	tated. the cause(s)	
	To th withir To th comp		29b. Signature and Ittle of certifier	10		29c. Licen	se number	290	d. Date signed (Month,	Day, Year)	
)			MULL	1		n	11218		104/04/0	04	
	3		30. Name and address of person who co Charles Harrison,				d. Rockvi	ille, MD 2	20855	-	
:	, Sta		31. Date filed (Month, Day, Year)		trar's Signature	4	/ ,				
	Registr	ar .	OCT 0	5 2004	Sereva	10 10	souks!				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death SEPTEMBER 30 2004 **Physician** GERALD LENWOOD WALKER 4:21 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 □XM 2 □ F Director 218-38-2203 64 13, 1940 Brunswick, MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location *netural; or items 23a or 28a-f show 10d, Inside City Limits Maryland Frederick 1 Yes 2 No Rosemont Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3529 Petersville Road 21758-9110 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "netural", or ite 1ry or other treumatic event, the Medical Exar. It will 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Iron Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lenwood Walker Mary Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Walker / Wife 3529 Petersville Rd., Knoxville, MD 21758-9110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery | Oct. 5,2004 Petersville, MD permit.
Deportri
importe
any nju 21. Signature Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 outer 23a. Part 1. Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, there, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OCARDIAL **Physician** disease or condition resulting in death) hour /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 -Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 \ Homicide Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 44121 iduson Drive Frederich MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 406 1 nomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CHUNG YAO Sept 12:00 M 30,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Hosp. Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 1 April 1 | 1919 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 China 1**⅓**M 2□F 85 Director Yrs. 228-33-275*6* Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Rockville Director Yes 2 No Md Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23e 100 Monroe Street, #302 20850 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ ♠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō þ 1 XYes 2 □ No 3 Widowed 4 Divorced "natural", Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. It and Mental Hygiene. 7 Is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) None Unknown 12 th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a.
Important: If Itam 27 la
any injury or other trau Shu Yun Yao (Wife) 100 Monroe St, #302, Rockville ,md 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State ⁴ □ Donation 5 □ Other (Specify) Metro Crematory 10/2/04 Alexandria, Va 21. Signature of Funeral Service Licen -e 22. Name and Address of Facility Snowden Funeral Home P.A. 20850 neuro 246 N. Washington St, Rockville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 Mont Immediate Cause (Firlal Physician Respiratory Failure disease or condition resulting in death) Month /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia 1 Month Sequentially list conditions, Physiclan/Medical Examiner Due to (unas a consequence of) day leading to this adicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attanding Physicien: The law requires that the death certificate be executed physician and s the burial-transit Congestive Heart Failure 2 Weeks Due to (or as a consequence of): Box 68760 IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month 4☐ Pregnant at time of death Day Year 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. icate has been sig. Atrial Fibrillation 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Be Completed Gastroesophageal Reflux Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy of Vital 1 Yes ⊉© No 1 Yes 2□ No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funarel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uclo D-34969 Sept 30, 2004 Man a 30. Name and address of person who completed cause of death (I em 23a) (Type, Print) Victor Chiang M.D 9707 Medical Center Dr, Rockville, Md 20850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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	1		Registrar 1. Decedent's Name (First, Middle, Last)			inoate or E	704111	2. Date of Dea	Reg. No.	111.	3. Time of Death
	Physicia	an	1) 1 1	idorf, J	R.			Month	Day	Year	200 NM
	/Medic Examin		4a. Facility Name (If not institution, give street a		1< 3	4b. City, Town, or	Location of Death		4c. Coi	unty of Death	5000
	Examini	eı	University of	Maryland		Balt:	imore			N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last l	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h V Vear	9. Birthp	lace (State or Foreign
ш	Director		219-05-7802	□F 84	Yrs.	Months Days	Hours Min.	03/26/1	920		land
	D .		Usual Residence of Decedent	10c. City, To	un orloa	etion				1	Od. Inside City Limits
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	with ti	급	10e. Street and Number 116 Prospect Drive			10f. Zip Code			U.S.		ury :
	s 23s	eral		s Decedent Ever in U.S.	13 W	207		nacify Vas or No.		Race - Americ	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f ahow any injury or other traumetic event, Ite Medical Examinational Contest and Leading of the December 2006.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐	ned Forces? LYes 2 □ No es, Give WW II	- 1	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 1 No	Specify:	o Rican, etc.)		Black, White, ecify: Whit	etc.
21215-0036	2 hou	ted	15. Decedent's Education		a. Deced	ent's Usual Occupa	ition	king	16b. Kind	of Business/In	dustry
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7	giene giene	Con	12	Se	elf E	mployed					r Condition
ם	al Hy al Hy d oth	3e	17. Father's Name (First, Middle, Last)	_			18. Mother's Nan			тате)	
Va	Ment Ment arked etic	2	Robert Jerome Zindorf					ne Muste			
Maryland	2 sho and lam		19a. Informant's Name/Relationship (Type, Print			Address (Street a					Code)
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o o	ges 1 t of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova			ition (Name of atory or other place				ion - City or To	
Baltimore,	tmen tent: tent:		'4 □Donation 5 □Other (Specify)	Metro	_	tan Crem					Virginia
Bal	permi Depar Impor any ir		2. Signature of Funeral Service Licensee	Balan	65	Name and Address	ain Hwy.	Bowie,	Maryl:	ome and 207	
			23a. Part1. Enter the disease, of complications shock, or heart failure. List only one caus	that caused the death. Doe on each line.					rest,		Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition	Cervice	215	SPINE +	ractu	ve_			
8	/Medical Examiner		resulting in death)	ue to (or as a consequenc				Mall.	Mark R		
	- Adminior	L	Sequentially list conditions, b	us to (or as a consequenc	and.		A	TENCH EN			
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	10 to to as a consaduant	3 017.	- 6	W are	D BY M			
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687	ficate physics the l	edical	G								
Вох	death certificate be executed e attending physician and od for use as the burial-transit	Physician/M		es, outcome of pregnancy	4b 2 🗆	F-4i			23d	. Date of delive	ery
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Ö.	that the de led by the a detached	hys	9 □Unknown	Unknown							
S, P	es tha igned be de	by	Part II. Other significant conditions contributing	ng to death but not resulting	g in the un	derlying cause give	en in Part I.			•	ne cause of death?
Vital Records,	law requires as been sign 2 should be	ompleted						1 🗆 \	105	10 3 T F 100	ably 4 Donkhown
ec	e law re has be	nple						24a. Was autop	osy	prior to co	psy findings available mpletion of cause of
=	Th ate pag	S							rmed? 2₩ No	death?	2□ No
/ita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examples?			Oth	The same of the sa	ath (Check only o	ne)		
of	Physi this c	5	to Yes 2 □ No Hospita	ny inpatient 2 EH/	Outpatient o. Time of	3 □ DOA Othe	4 🗆 Italishig t	lome 5 Residence 128d. Describe 1			y)
		lon	1 □Natural 5 □ Pending	(Month, Tay Year)	Injury	28c. Injun Worl M 1 □	·/	EC. ILI	- 200	Caron	4.3.1
isi	ten leat lor: the	cat	Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home,	farm stre)	103 254.110	28f. Location (5	Street and N	umber or Rura	l Route Number,
Division	in Sir fe	Certification:	4 Homicide determined	building, etc. (Specify)	Но	-		City or Tov	vn, State)	l16 Pro	spect Drive
_	pital ours beral filled		29a. Certifier 1 Kertifying Physician:	To the best of my knowled			ne, date and place	Fort Wa			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examiner: O								
	ro th within ro th	Me	29b. Signature and title of certifier			2 c. License	number		29d. Dare si	igned (Month,	Day, Year)
	->-0		15hold			HV11	INA C	4911	100	2104	
0	1 /2	1	30. Name and address of pirson who complete	od cause of death (Item 23)	a) (Type, I	Print)		- 1	, 10	1	
A	-(5/1	la	T. Shepherd, M.D. 2	2 South (gree	11 Stre	et I	salto,	MD	2120	
•	Sta Regist		31. Date filed (Month, Day, Year) OCT 0 4 2004	Registrar's Signature	Soo	de la					

State

Box 68760.

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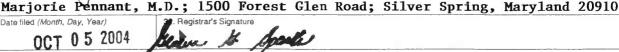
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of Vital

Division

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



OCT 0 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

V006159

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death 200 3. Firme of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year October Edna Banks 4 2004 9:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cresent Cities Nursing Home Riverdale
If Under 1 Year If Under
Months Days Hours Prince George's 5. Social Security Number 9. Birthplace Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Min 1□ M 2 → F Director 579-<u>32-7503</u> 1925 Washington, DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Michael Examitter must be notified at 10d. Inside City Limits 11 Yes 2 No Directo MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 7709 Georgian Drive 20772 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filled within 72 hours after tent of Health and Mental Hygiene. Int if item 27 is marked other then "neturel", or Ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☑ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) yrs Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Allen ೭ Mary Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Banks/Daughter 7709 Georgian Drive Upper Marlboro, Maryland 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Peramation 3 Removal from State permit. Page Department o Importent: If any injury or QBGG. injury or * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Ceme 10-11-04 Suitland, Maryland 21. Signiture of Funery Service Lice 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 DSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the attending physician thed for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à emer 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy ormed? 1 Yes Hospitel or Attending Physicien: To hours after death. Funerel Director: After this certificate tely filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel Within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48213 04/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Neelam M.D. 4410 74th Avenue Landover Maryland 20784

DHMH 17 Rev 1/2001

State

Registrar

Registrar's Signature

5 2004

05

31. Date filed (Month, Day

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Nen 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Sally Ann Borders September 26, 2004 9:25 a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Brookeville 1800 Gold Mine Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M & F Yrs. June 1, 1928 North Carolina Director 241-36-9276 76 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ir then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1√Yes 2 No Montgomery Directo **Brookeville** Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20833 1800 Gold Mine Road United States Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 If Yes, Give Year or Dates: 2K No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental F Alvis Ross Angeline Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s Health an Avia Robinson/Daughter 1800 Gold Mine Road Brookeville, MD Hem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny injury or ot
once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 10-5-04 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 21. Signature of Funeral Service Licenses wa 20747 5538 Marlboro Pike/ Forestville, MD 23a. Part1. Enter the new sign or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG **Physician** CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of): the burialattending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year ĺ 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ HUPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed END-STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 1 ☐ Yes 2 ☐ No certificate ! DIABETES MELLITUS 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cthen 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 ins. funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Shuch 10012004 MD32307

CK

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

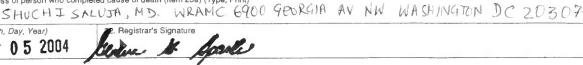
State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

OCT 0 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Amended #19b, nls, 10/05/04, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

05/	'04, AL	Leg	zany Co. 1 – State Registrar	State of Ma	-	partment of Fertificate of	lealth and Me Death		ene	32903
			Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		WILLIAM JUN	IOR BEVE	RLIN		C	e tobe ?		12:60 PM
Ì	Examin	er	4a. Facility Name (If not institution,	- ,	0 .		r Location of Death		4c. County of Deat	
			SACRED HEA			Cumbe			ALLEGI	
	Funeral			Man alle	ge (In yrs. last birthda On Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y July 25,	9. Birtl	hplace (State or Foreign untry)
	Director		233–34–7351 Usual Residence of Decedent		80 Yrs.			July 25,	1924 WES	T VIRGINIA
	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	the Marylar 28a-f show	tor	WV MINE	RAL	FORT	ASHBY				1 □ Yes 2X No
	ith the	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	23a c	aj E	BRIDGE ROAD			2671	L 9		U.S.A.	
	tems	nuel	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1:	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
36	72 hours after death with the Maryland "neturel", or items 23e or 28e-f show olical Examilinar must be notified at	by Fi	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 ☐ If Yes, Give Year or Dates:	N°WWII	1 ☐ Yes 🏋 No	Specify:		Specify: TATE	HITE
215-0036	hour furel	ed b	15. Decedent's		16a. De	cedent's Usual Occup	pation	16	b. Kind of Business/	
15	n "ne	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Gi	ve kind of work done . DO NOT use retired	during most of workin	g		
212	yiene.	Completed	11	College (1-4or	CA	RPENTER			CARPENT	RY
	al Hyg othe	Be C	17. Father's Name (First, Middle, L				18. Mother's Name		iden Sumame)	. "
/ar	should be filed within and Mental Hygiene. I marked other then umatic event, Ira M	To	HOMER BEVERL	IN			OLIVE C	CROSTEN		
Maryland	2 2 2 3		19a. Informant's Name/Relationsh			•	and Number or Rural		•	
	1 and Health Health tem 27 other tr		CARRIE R. BEV	ERLIN / W	V.	position (Name of	L - FORT			
Baltimore,	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 Description 2 Comparison		cemetery, c	rematory or other place	ce)		c. Location - City or	
tim	t. Pa rtmen rtent: njury		* 4 □ Donation 5 □ Other (Sp		COMBERLA		ORY 10/04/		CUMBERLA	ND, ND
Bal	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other <u>once</u> .		21. Signature of Funeral Service L	n. upch	ure	P.O. BOX	FUNERAL H 1260 – FO	RT ASHBY	,WV 2671	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused only one cause on each li	d the death. Do not e ine.	enter the mode of dyin	ng, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a CONS	eme !	terni to	Love			2years
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	1				0
	=xa	-	Sequentially list conditions,		a consequence fix	351000	BENTE			Contraction
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0) (0)	1,					
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	cate be executed oblysician and the burial-transit	dicail		d.						
9	uficat g phy as th	ĕ								
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pregnancy	,		23d. Date of deli	*
	deat	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant a		Other (specify)	,		Month	Day Year
P.0	that the death cer ed by the attendir detached for use	h	9 🗆 Unknown							
	res tha igned be det		Part II. Other significant condition	1 -		underlying cause giv	en in Part I.		co use contribute to	othe cause of death?
Records,	w requir been si should	Completed by	CONTRACTO O LA	color D	130.30			1 Tes	2 □ M6 3 □ Pr	obably 4 Donkhown
ec	law las b	nple	Dava Fali	×Q_				24a. Was an autopsy	prior to d	topsy findings available completion of cause of
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Vita	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		iont 3 DOA Oth	26. Place of Death			
of Vital	Phye this ral dii	. To	1 Yes 2 DO	28a. Date of Inju		IGHT 3L DOA	4 Nursing Hon	ne 5 Residence 8d. Describe how	injury occurred	cify)
no	ding h. After fune	tion	1 Natural 5 ☐ Pending	(Month, Da	ay Year) Injur	y Wor	rk? Yes 2 □No		,,	
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Ö	after after Dire d in b	Certification;	4 Homicide	building, et	tc."(Specify)		-	City or Town, S	State)	
	pepit hours inere	aic		Physician: To the best						
	To the Hoepitel or Attending Phyeicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical E	Examiner: On the basis of and manner st	tated.		·			
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	,) . '	20	29c. Licens			. Date signed (Montl	h, Day, Year)
15	PIUA			Koser V		T E	31875		CCTCIBE	- 4 2cod
	nes		30. Name and address of person were person with the second		death (Item 23a) (Typ		berland,		51205	
3	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 5 2004	32. Registr	rar's Signature	books				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of M	ıaryıar		aπment <i>rtificate</i>			ina Me	-				
			1. Decedent's Nam	e (First, Middle, Las	st)							2. Date of De	ath	04	3 Time of	Death
	Physic	an				n						Month	Day	Year		
1	/Medi		Harold		David e street and number		wers			4h City Toy	em or Loc	Octobe ation of Death		2004 y of Deeth	11:35) AM
	Exami	ıer		_						•	•					
			5. Social Security N		or Nursing		le last birthday,	If Under	1 Year		0ak1			Garret		or Foreign
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	death with the Maryland ms 23s or 28e-f ehow I must be notified at		Usuel Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation	_					10	Od. Inside Ci	
	with the Maryle 3a or 28e-f ehor	cto	MD	Gai	crett			(0ak]	Land					1 ∐ Yes	2☑ No
	를 2 8	Sr.	10e. Street end Nur	mber				10f. Zip	Code				10g. Citizen of	What Count	ry?	
	11 w	B	1409 Sn	nouse Road	i					215	50			USA		
		Funeral Director	11. Marital Status		12. Was Decedent Armed Forces	Ever in U	,S. 13.	Was Decede	ent of F	lispanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	- 14. Ra	ce - America		
Maryland 21215-0020	within 72 hours after ene. than "naturel", or its in Medical Exemina	by Fu	1 ☐ Never Merri 3 ☑ Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2☑ If Yes, Give Yeer or Dates:			1□Yes 2			, , , , , , , , , , , , , , , , , , , ,	,,	Specif			
Ģ	2 ho	Completed		15. Decedent's Ed	ucation		16a. Dece	dent's Usual	l Occup	ation			16b. Kind of B	usiness/Ind	ustry	
75	n n	D D	(Speci	cify only highest gra	de completed) College (1-4or	E.\	(Give	kind of worl DO NOT use	k done e retired	during most d)	of working	9			-	
7	the dead	E	10th	mary (0-12)	College (1-40)	5+)		Mi	ner				Coa1	Minin	C*	
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<u>a</u>	ic ever	0	Garfield				Bowers			Elsi	e		-]	Harvey	7	
a S	s i and 2 should be filed if Health and Mental Hygle tem 27 is marked other other traumatic event, it	-	19a. Informent's Na	ame/Reletionship (7	ype, Print)		19b. Maili	ng Address	(Street	and Number	r or Rural	Route Numbe	er, City or Town			
	nd 2 lith a 27 Is		Sue Fulm	er/daught	er		203	9 Mary	y1ar	nd Hwy	., Oa	akland,	Md. 2	1550		
Baltlmore,	ges 1 and 3 to of Health If Item 27 or other tr		20e. Method of Disp		Removal from State		Place of Disponentery, cre-	osition (Nam metory or ott	ne of ther plea	ce)	l	Date	20c. Location	- City or Tov	vn, State	
틒	2 2 2 2	Į.		5 Other (Specify		De	er Par			_	110	0/7/04	Deer I	Park,	Mary1	and
3al	permit. I Departm Importar eny inju		21. Signature of Fu	neral Service Licen	see		_	2. Name and tewart				2				
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1	/Medical		Immediate Cause (disease or conditio	Final	. Dem	tura	1							1	MONT	. 14.6
	Examiner		resulting in death)		a		or es a conse	quence of):							TON	11)
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	dea ed fo	8 C	Part II. Other signifi	icant conditions co	ntributing to death b	ut not resi	ulting in the u	nderlying ca	use giv	en in Part t.		23b. Did t	obacco use co	ntribute to	the cause o	of death?
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5	th. : After e funer	Ö	 Manner of Death Naturel 	5 Pending	28a. Date of Inju (Month, De	y Year)	28b. Time of Injury		Sc. Injun			d. Describe h	ow injury occur	red		
Division	ttendi death stor: A y the fi	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be				М		Yes 2□N						
\leq	or Att	퉤	4 Homicide	determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>)	ome, farm, str /)	eet, factory,	office		28	f. Location (S City or Tow	itreet end Numb n, State)	er or Rurel	Route Num	ber,
	ospital o hours at unerel D	8		1												
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Certification:	29a. Certifier (Check only one)	1 ✓ Certifying Phy 2 ☐ Medical Exam	sician: To the best iner: On the basis of and menner st	f examinat	wledge, death tion and/or in	occurred at vestigation, i	t the tim in my o	ne, date and pinion, death	place, an occurred	d due to the c l et the time, d	ause(s) and ma late end place,	inner as sta and due to f	ted. the cause(s	i)
	To the to the total of the tota		29b. Signature end	title of certifier		_		29c.	License	e number		2	29d. Date signe	d (Month, D	ey, Year)	
	, 0		1 M2	Sand	me		Ne		Н	26154			101	1410	04	
		-	30. Name end addre	ess of person who o	ompleted cause of d	leath (Item	23a) (Type	Print)	**				/	1		
				iel Mille				,	. 0	aklana	1 MA	. 2155	Λ			
	Sta	te	31. Dete filed (Mont		32. Registr			o DI.	, 0	~ KI GIIC	riu er	. 2177	<u> </u>			
	Registr	ar	1	001 - 6 %	.004	Willed .	13									

DHMH 16 Rev 6/95

		1 - For Amend Item 281 per me 6836 10-27 We Las Health and N Registrar Certificate of Death		Reg. No.	01.	220	nc
Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of Dea		Year	'3. Time of	Death)
/Medic		James Upshur Barnes	Octobe			1515	РМ
Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County Wico			
		Peninsula Regional Medical Center Salisbury 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt			lana /Stata a	r Fomian
Funeral Director		214-18-4420 10xm 2 F 84 Yrs. Months Days Hours Min.	05/07/	v, Year)		lace (State of try)	
		Usual Residence of Decedent	03/0//	1920	Mar	yland	1
nylan how		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside Cit	y Limits
e Ma ta-fa	ctol	Maryland Wicomico Salisbury				1 Tes	2 X No
ith th	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Coun	try?	
death with the Maryland ms 23a or 28a-f ahow croust be roulified at	-ea	6255 Westbury Drive 21801		USA			
er de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,		
od within 72 hours after giene. ar than "naturat", or its iro Medical Exatura	by F	1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates: Army		Specif	y:	hite	
hour turat		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of B			
in 72 "nai	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ring	100. KING OF B	nzmezzymo	lustry	
with iene	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12 - Contractor		Build:	inaca	netr	nat i
filec Hyg otha ant,	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Maiden Suman	18)	MIS CI	لالمالك
Ald by Alenta rkad	To B	George Barnes Mary	Stag	ıg			
s 1 and 2 should be filed within 72 hours after death with the Marylar Realth and Mental Hygiene. It Health and Mental Hygiene. It is marked other than "naturat", or itams 23a or 28a-f show other traumatic evant, I'm Medical Evarianer must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Numbe	r, City or Town,	State, Zip	Code)	
and 2		James B. Barnes/son 9060 King Fisher (t.,Heb	oron, N	1D 21	830	
Permit. Pages 1 a Department of He mportant: If itam any injury or othe		20a. Method of Disposition 20b. Place of Disposition (Name of Company) of the Company of the Com	Date	20c. Location -			
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permit. Pages Department of Important: If i any injury or o		21. Signature of Janeral Service Licenses 22. Name and Address of Eacility HOIIOWay Funera 501 Snow Hill R	l Home	Profe	essic	nal A	Assc
		23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	d.,Sal	isbury	, MD	21804 Approximate	1
Physician /Medical Examiner	-C-	stock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. However to blockage of Du to for a a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of):	Aivwa	7		Interval Betw Onset and D	eath
cate be executed ohysician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.					
death certifi e attending p id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			te of delive		ear
w requires that the de been signed by the a should be detached t	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use cont es 2 Xvo	ribute to the		eath? nknown
The law ate has b	Completed		24a. Was a autops perfor 1 Yes	sv r	prior to com	esy findings an appletion of ca	vailable use of
ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital: Other Other Other					
Physician: this certific ral director,	. To	1 Inpatient 2 Set-Proutpatient 3 DOA 4 Nursing Ho	me 5 Residence 128d. Describe he				
ding Phys th, After this funeral dir	Certification:	1 Natural 5 Pending (World, Day Year)	ChoKed	on pla	Stice	Riove	
Attanding r death. actor: After by the fune	lica	Could not be	28f. Location (S				ner
after Dira	erti	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	5200°C	State) Dr	LVE	er Dr	re
To the Hospital or Attandli within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the time an	and due to the c	ause(s) and ma ate and place, a	nner as sta and due to	ated. the cause(s)	
the tthin the omple	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed	(Month. E	Pav. Year)	
⊢≯Fö		Carol Hallannel O.C.M.E.		October			
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
Sta	te	CITKOL H. ALLAN Wd 111 Penn Street, Bal 31. Date filed (Month, Day, Year) 32. Registyar's Signature	timore,	Marylar	nd 21	201	
Registr		OCT 1 4 2004 Deneva & Sparks					

			1 - For State Registrar	State of Ma	aryland /		artment rtificate			ind M	ental Hy	gien Reg. Né	2001.	329	0.7
П	Physic	ian	Decedent's Name (First, Middle, La	ist)							2. Date of De	aath Da	y Year	3. Time o	
	/Medi	cal	Roy	Vernon		Beau	champ				09	29	2004		5 M
	Exami	ner	4a. Facility Name (If not institution, giv						Location o	f Death		40	. County of Dea		
	Funeral		Peninsula Region 5. Social Security Number 6. S		Cente		Sal If Under	isbu 1 Year	ry If Under 2	24 Hrs.	8 Date of Rig	th.	Wicomic		or Coming
	Funeral Director			M 2□F	9	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 01-17-			rthplace (State ountry)	or Foreign
	P .		Usual Residence of Decedent								01-17-	1933	ria:	yland	
	arylau show	_	10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside C	
	he M	ecto	MD Wicomi 10e. Street and Number	co	Sal	isbu:									2 🗆 No
	with 1	Funeral Director		-1- D . !			10f. Zip		0.4			10g. Ci	tizen of What C	ountry?	
	leath ns 23	era	30219 Stoneybro		Ever in U.S.	13. \	Was Decede	218		in2 (Sne	city Yes or No		USA 14. Race - Am	erican Indian	
(0	ifter d	臣	1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 XYes 2 1	No.					Puerto F	cify Yes or No Rican, etc.)	-	Black, Wh		
5-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show discal Examinar must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Korean		1☐ Yes 2	No.	Specify:				Specify:	hite	
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121	Hygie Hygie other t		12 17. Father's Name (First, Middle, Last	4		Rea1	Ltor	1	19 Mothor	r's Namo	(First, Middle,		al Esta	te	
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic avant, Tre Ms	To Be	Vernon A. Beauch					-			Pusey	, Maider	Sumame)		
Z	should nd Men marka ımatic	Ĕ	19a. Informant's Name/Relationship (1	15	9b. Mailin	a Address	(Street a				er City	or Town, State,	Zin Code)	
Z	and 2 lealth ar m 27 is har trat		Ruth Beauchamp/W	ife									ury, MD		
Je,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itams 23a or 28a-1 show amy injury or other traumatic avant, the Medical Examiner must be notified at any injury or other traumatic avant, the Medical Examiner must be		20a. Method of Disposition	35	20b. Place cemei						ate	_	ocation - City or		
Ш	Page nent c ant: If ary or		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif	JRemoval from State (y)						10-0	3-2004	Pri	ncess A	nne. MD)
Baltimore,	permit. Pag Department Important: any injury c		21 Signature of Funeral Service Licer	nsee /		22	. Name and	Address	of Facility	,				, III	
	20599		JENESE SUR		100295		673 S	omer	set A	lveni	ıe, Pri	nces	ss Anne	MD 21	853
*			3a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do	o not ente	or the mode	of dying	, such as c	ardiac or	respiratory a	rrest,		Approximat Interval Bet	ween
	Physician		Immediate Cause (Finat disease or condition resulting in death)	a. Cer	elon	rl	M	un	la	260				Onset and	Death
	/Medical Examiner		1	Due to (or as	a consequence	e of):	1	1	/_	/	n de		o _b	1	
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as:	a consequence	e of):	ruc	V	OSCI	u	n au	old	31	year	2
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0											
o o	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence	e of):									_
8760	cate be ex physician the buria	dicai	•	d											
9	death certifica attending ph d for use as th	Mec	IF FEMALE:	00. 1/											
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal deal		Ectopic pre						23d. Date of de Month		Year .
Ö	that the de ed by the detached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time or death	5	Other (spe	crty)						,	
٩.	res that the igned by be detac		Part II. Other significant conditions of	ontributing to death bu	ut not resulting	in the un	derlying car	use giver	n in Part I.		23e. Did to	obacco u	se contribute to	the cause of d	leath?
rds	quires n sign	q pe	Consistine	Lears -	Sail	une					101	es 2	No 3 □ P	obably 4 🗆	Jnknown
00	aw requii s been s 2 should	piet	AT Leves clines	Tie les	25	de	in	0			24a. Was	an	24b. Were au	topsy findings	available
Vital Records,	The lay	Completed by				- Lare 0						rmed? 2 X No	prior to death?	completion of ca	ause of
ita	ysician: The l is certificate ha director, page	Bec	25. Was case referred to medical examiner?						26. Place o	of Death	(Check only o		10165	20 140	
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No		nt 2 ER/C	Outpatient	3□ DOA	Other	4 🗌 Nurs	sing Hom	e 5 ☐ Resid	lence (3 □Other (Spe	cify)	
	ding Phith. th. After thi	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Ye <i>ar</i>) 28b.	. Time of Injury		c. Injury a Work?			3d. Describe h	iow injur	y occurred		
isio	ttand death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be		A h	·	М		es 2 No		26 1				
Division	after death	Certification:	4 Homicide determined	28e. Place of Inju building, etc	. (Specify)	rarm, stre	et, ractory,	office		28	City or Tow	itreet an n, State	d Number or Ru)	ifal Route Num	ber,
_	e Hospital 124 hours a la Funaral E letely filled		29a. Certifier Certifying Ph	ysician: To the best o	f my knowledd	ge, death	occurred at	the time	date and	place an	nd due to the o	rause(s)	and manner as	stated	
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	edical	(Check only 2 Medical Exan	niner: On the basis of and manner sta	examination a	ind/or inve	estigation, in	n my opi	nion, death	occurred	at the time, o	date and	place, and due	to the cause(s))
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	0/				License i		08	2	29d. Dat	e signed (Monta	n, Day, Year)	
			Clas FALL	160ct	mo	-	D	00	192	87			9/29	104	
امر	5		30. Name and address of person who	completed cause of de				75.	No.		017		112:		
. (1	,		31. Date filed (Month, Day, Year)	32. Regi st ra	131	15 1	out	DIVI	sion	5V.	Solishu	y !	10 218	7	
	Sta Registr	1	OCT 0 4	2004	r's Signature	4	lan. V					/			

Noy Beauchamp

	-	For State		State of N	/laryland		artment c <i>tificate d</i>			1ental Hy	-	1000	22200
Physici		Registrar 1. Decedent's Nam	ne (First, Middle, L	_ast)	_	061	uncate	Deal		2. Date of De	Reg. No.		3. Time of Death
/Medic	al	Walter		Leroy		Bozi	nan, Sr			9	30	2009	1
Examin	ŭ'	Peninsull	a Region	ive street and numbe	21 00	nter		Salist	411	,		Wiram	iko
uneral irector		5. Social Security N 217-28-47	727	Sex 7. A	Age (In yrs. Ias 73	t birthday) Yrs.	If Under 1 Y Months Da	ear If Und ays Hour	der 24 Hrs.	8. Date of Bi (Month, Di 05-03-	ay, Year)		rthplace (State or Forei ountry) yland
M II		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limit
e or 28a-f show Le notified at	ţo	MD	Sor	nerset	Wet	nona							1 XYes 2 □ N
or 288	Director	10e. Street and Nu		nc13cc	, wei	iona	10f. Zip Cod	de			10g. Citi	zen of What C	ountry?
2 3		23213 Pa	aul Bento	on Circle				218				USA	
al Examinar m	by Funeral		ried 2 Married	If Vac Cinco	s?] No		Vas Decedent Yes, specify (□ Yes 2□			ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	te, etc.
N. I	ed b	3 Widowed	15. Decedent's		Korea		lent's Usual O	ecupation			16b Ki	nd of Business	ite
IR MEAN	Completed	(Spe Elementary/Sec 10	cify only highest g	College (1-40		(Give	kind of work do DO NOT use re	one durina n	nost of work	ing		eafood	undustry
evelli, Eg	Be Co	17. Father's Name	(First, Middle, La:			wate	Lillan	18. Mc	ther's Name	e (First, Middle			
	To B	Charles	Bozman					Ma	ry Boz	zman			
treumatic		19a. Informant's N	lame/Relationship	(Type, Print)		19b. Mailin	g Address (St	reet and Nur	nber or Rura	al Route Numb	er, City o	r Town, State,	Zip Code)
		Margaret	t Bozman,	/Wife					n Circ	le, We	nona	, MD 21	821
		20a. Method of Dis		☐Removal from Stat	20b. Plac	e of Disponetery, cren	sition (Name on natory or other	f place)		Date -	20c. Lo	cation - City or	Town, State
		` 4 □Donation	5 Other (Spec	cify)	1	nan Fo	ord Cem	etery	10-04	-2004	Dana	s Quar	ter, MD
any mjury or or		21. Signature of F	uneral Service Lic	ensee)	H.	Name and Ad Lnman F	dress of Fa unera.	L Home	2		10	
cian dical	6	21a. Part1. Enter shock, or hea Immediate Cause disease or conditi- resulting in death)	art failure. List on (Final on	mplications that als ly one cause on each	line.	Do not ente	er the mode of	dying, such	as cardiac o	or respiratory a	arrest,		MD 21853 Approximate Interval Between Onset and Death
miner	.		ſ	a. Moca v. Due to (or a	t Coro	nce of):	Artery	Bu	Pas	5'			18hu
sicien and burial-transit	Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death)	S 💮	c. 45C	f Conseque								12 yrs
as the buria	<u>ea</u>				cordi		Ingline	Len	_				8 days
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d be detached	d by Ph	Part II. Other signi	ificant conditions	contributing to death	but not resulti	ng in the ur	nderlying cause	given in Pa	rt I.		tobacco u Yes 2[o the cause of death?
been si	ete	0 15	A.	20		15	-	-		:			,
9		Sance A	this	Gulmon holis De	replan	dine.	twal	disk	än	24a. Was auto perfe 1 \(\text{Yes}		death?	utopsy findings available completion of cause of 2
certificate rector, pag	o Be	25. Was case refe examiner?		Hospital:						(Check only			
After this funeral di	—	1 ☐ Yes 2 ☑ 27. Manner of Dea 1 ☑ Natural 2 ☐ Accident		28a. Date of In		VOutpatiens Bb. Time of Injury	28c. I	njury at Work? 1 □ Yes 2	_ 2	me 5 Resi 28d. Describe		Other (Spe	vcify)
Director:	Certification:	3 Suicide 4 Homicide	6 Could not determine		njury - At home etc. (Specify)	e, farm, stre	eet, factory, off	ice	1	28f. Location (City or To	Street and wn, State,	d Number or R	ural Route Number,
To the Funerel I completely filled	ledical C	29a. Certifier (Check only one)	1 Certifying I	Physician: To the bes aminer: On the basis and manner:	of examination	edge, death n and/or inv	occurred at the	e time, date ny opinion, d	and place, a leath occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
4 0	Me	29b. Signature and	d title of certifier		2		29c. Lic	ense numbe	er e		29d. Date	e signed (Moni	h, Day, Year)
o E		Van	1 16	2/1/ 1	//		1	020	28		91	30/2	/
Eoo		Muc	Killed V.	1 neces	e an		1	000				- 9/0/4	7
To the comple		30. Name and add	. 1	o completed cause of Buch n	death (Item 2	3a) (Type, I				ff R	//	Salich	ury MD

Amend item#19b, per INF, G837, III/23/04 TI
State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend item#4a, perMD, G838, 12/en/this and of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CHIPLIS **Physician** JOSEPH DANIEL 2̈́9, 2004 3:00 P Sept /Medical 4a. Facility Name (If not institution, give street and number)

1005 Eton Rd.

1005 Bead, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months 1√ M 2□ F 51 312-62-4140 Yrs Director 4,1952 Indiana Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examplest must be rectified at 1 ☐ Yes 2X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 Eton Road U.S.A. 9005 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 3434No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: SpecifyWhite þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Smithsonian Elementary/Secondary (0-12) College (1-4or 5+) Public Horticulturist 5+ Institute 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Felix A. Chiplis Margaret E. Burkhard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2005 Eton Road Silver Spring MD 2090 19a. Informant's Name/Relationship (Type, Print) Paula Chiplis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Merk Funeral Srv 10-1-04 ' 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature Funeral Service Loshiee 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Lymphocytic Leukemia 4 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause for the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 🏖 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Startence 6 Other (Specify) 2 1 ☐ Yes 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this hours after death. Ineral Director: After this y filled in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending txtatural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-1-04 0044629 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe St., 21205 Baltimore, MD Ian Flinn, 600 N. M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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4)		beer	lete										24a. Was	s an	24b War	a autor	osy findings available
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6				25. Was case refer	red to medica							00 Plans of Pa			0 1 🗆	Yes	2 🛂 No
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11 n J n	Division	after dea Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be nined 28e. Place built	ce of In	jury - At ho ic. <i>(Specif</i>)	ome, farm, str	eet, factory,	office		28f. Location (City or To	(Street a	and Number o	r Rural	Route Number,
2	DIVISION Of VITA	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Co	29a. Certifier (Check only one)	1 Certifyir	ng Physician: To the Examiner: On the	basis c	f examina	wledge, death	n occurred at vestigation, i	t the tim	ne, date and place pinion, death occu	a, and due to the arred at the time,	cause(s) and manne	r as sta due to	ated. the cause(s)
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				State of Ma	ryland /	Certifica			d Mental H	ygiene Reg. No.2	04 3	2911
	Physic: /Medi		1. Decedent's Name (First, Middle, Las Adrian Lyle Ca	nter					2. Date of D Month Septe:	Day mber 30,	Year	Time of Death: 10 pm
	Examir		4a. Facility Name (If not institution, give	street and number)		-		4b. City, Town,	or Location of Dea			
	Funeral		Millenium Health (5. Social Security Number 6. Se	ex 7. Age	Bel Pre	rthday) If Un	der 1 Year		rs. 8 Date of F	lirth	gomery 9. Birthplace	(State or Foreign
	Director		370 03 0040	MM 2□F	94	Yrs. Month	ns Days	Hours N	fin. $July 3$	3, 1910	Mary1ar	nd
	D s		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location					404.1	- 11- 02- 11- 2
	Aaryla F sho	5										nside City Limits
	28e	Directo	Maryland Montgomer	. У	Takoma		Zip Code			10g. Citizen of		
	3a or		605 Hudson Avenue	#114			912			U.S.A.	rinat country.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U,S.			Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)		ce - American In	ıdian,
020	172 hours after death with the Maryland "netural", or Items 23a or 286-f show patical Evantaire Critist De profittled at		1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			2 X No		ierto Rican, etc.)	Specif	ck, White, etc. by: White	<u>:</u>
2-0	72 ho	ted	15. Decedent's Edu (Specify only highest grad	ucation	16a	Decedent's U	sual Occu	pation	working	16b. Kind of B	lusiness/Industr	y
Maryland 21215-0020	d within jiene. r then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT	use retire	during most of a	working	Stone M	anufact	uring Co
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ylai	should be and Mental s marked o	ToE	Mitchel A. Cante	r				01a R.	Lamar			
ar	C1 (0 .0. B)	7 19	19a. Informant's Name/Relationship (T			_			Rural Route Num			,
	1 and 2 Health em 27 i		Patricia Dickens -	Daughter	-			venue #:	114, Tako			
Baltimore,	permit. Pages 1 ar Department of Heal Important: If item 2 any injury or other	1	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		cemete	f Disposition (A ry, crematory o	r other pla		Date		- City or Town, §	
<u>=</u>	artme artme ortani injury	l y	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		FORT L	incoln			10/04/04 Gasch's I		ood, Ma	
ñ	permi Depa Impo any ir		Claudette	Dasch	Jami				Avenue, I			
	Physician /Medical		Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final)	lications that caused the cause on each line.	ne death. Do	not enter the m	ode of dyi	ng, such as card	liac or respiratory	arrest,	Inter	roximate rval Between set and Death
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	tificate be executed g physician and as the buriel-transit	Examiner	Sequentially list conditions,	D. ———		consequence o	f):					
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P.O. Box	that the death cert ed by the attendin deteched for use	Physician/N										
o.	the d ny the ached	hysi	Part II. Other significant conditions con	ntributing to death but i	not resulting ir	n the underlying	cause gi	ven in Part I.		tobacco use co		
	es that igned b	by P	Hypertension						_ 'L	Yes 2□ No	3 Probably	4 X Unknown
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ā	siclen: The certificate l irector, pag	Be C	25. Was case referred to medical					26 Place of F	eath (Check only	Yes 2 X No	1 Li Yes	2 □ No
<u>=</u>	ysicle s cert direct	ToB	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Ou	tpatient 3	OA Oth		Home 5□ Res		er (Specify)	
0	Attending Physiclen: or death. ector: After this certific by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. 1	Time of	28c. Inju			how injury occur		
Ö	ath. or: Aff	atic	1 X Natural 5 Pending 2 Accident investigation	(101011111)	,,	M		Yes 2 □ No				
Division of Vital Records,	마 # F 드	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (rm, street, facto	ory, office		28f. Location City or To	(Street and Numb wn, State)	er or Rural Rou	te Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical (29a. Certifier 1	sician: To the best of ner: On the basis of example and manner state	camination and	, death occurre d/or investigation	d at the timen, in my c	me, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s) and ma date and place, a	anner as stated. and due to the c	ause(s)
	29c. Signature and title of certifier							se number		29d. Date signed	d (Month, Day,	Year)
1	B.		1 Hanstle	Kugu	400	(()	D4553	33		October	2, 2004	ł
(US,		30. Name and address of person who co	ompleted cause of deal	th (Item 23a) (
_	7		Daniel Snow, M.D.	19703 Ехе	cutive	Park C	irc1e	e, Germa	ntown, M	D 20874		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 5 2004	32. Registrar's	Signature							

DHMH 16 Rev 6/95

			For State Registrar		f Marylar	nd / Depa		t of H	lealth a	and M	ental Hy		9		200	110
			Decedent's Name (First, Middle	e. Last)			Timodi	0 0, 1	J 04111		2. Date of De			Page 1	3. Time	of Death
3	Physici		5								Month	Da		ear	06:	
	/Medio Examir		Denise Marie Cro 4a. Facility Name (If not institution		mber)		4b. City,	Town, or	Location of	of Death			. County of		00.	13
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		1 Year	If Under Hours		8. Date of Bir (Month, Da	th				or Foreign
Н	Director		215-68-6360	1□M 2\DIF	49	Yrs.	MOTILIS	Days	Hours	MID.	15-Aug				dand_	
	p ,		Usual Residence of Decedent 10a. State 10b. County		100 0	ty. Town or Lo	antina.									01-11-11-
	anyla ehov	2	Toa. State Tob. County		100. 04	ty, town or Lo	ocation							,	0d. Inside	es 2 X No
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	with t	Ö	10e. Street and Number	5 Vale Sumr	nit Road		10f. Zip	Code				Tug. Ci	tizen of Wh	at Cour	itry?	
	within 72 hours after death with the Maryland ane. than "natural; or Itame 23s or 28s-f show he Madical Example frimst be redifited at	Completed by Funeral Director	44 Marital Chabres	12 Was Doc	edent Ever in U	19 13	215		ispanio Ori	gin? (Sne	oifu Voe or No	U.S.	14. Race -	Amorio	an Indian	
	itam Itam	Į.	11. Marital Status 1 ☑ Never Married 2 ☐ Marri	Armed Fo	orces?	.3.	If Yes, spec	cify Cuba	in, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	,-	Black,	White,	etc.	
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	be filed ital Hygid of other	Be (17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle	, Maider	Sumame)			
/a	ould b Ment harked	To 1	Donald G. Crowe						Donr	na Bla	nk					
Maryland	and and is m		19a. Informant's Name/Relations	hip (Type, Print)						er or Rura	l Route Numb	er, City	or Town, St	ate, Zip	Code)	
	1 and 3 Health tem 27		Donna Rosenberg	er mot			Borden		Road	Frost			Maryla		2153	32-
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Demoval from		Place of Dispo cemetery, crea	nsition (Nam matory or o	ne of ther plac	e)		ate	20c. L	ocation - Ci	ty or To	wn, State	
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Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any Injury or other troppes.		21. Signature of Funeral Service	Licensee	./	2	2. Name an	d Addres	ss of Facilit	ty						
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f V	Physician: this certific ral director,	2	examiner? 1 Tes 2 No	Hospital:	Inpatient 2	ER/Outpatier	it 3□ DC	A Othe	er: 4□Nu	rsing Hor	ne 5 Resi	dence	6 Other	(Specify	1)	
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	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	edicai	29a. Certifier X Certifyir (Check only one)	ng Physician: To the Examiner: On the b and man	e best of my kno asis of examina ner stated.	owledge, deat ation and/or in	vestigation,	in my op	oinion, dea	d place, a th occurre	and due to the ed at the time,	date and	d place, and	due to	the cause((s)
	Vith To T	2	29b. Signature and title of certifie	'11 rd					number			29d. Da	te signed (/	Month, l	Day, Year)	
	15		- M					DGD	478	5		9	[30]	00	4	
	TINS		30. Name and address of person AFAQ AHMAD	1 110 8 /	se of death (Item	n 23a) (Type,		Cur	n ber	lar	I mot	, 2	150	2		
	Sta Regist		31. Date filed (Month, Day, Year)	004 34	Registrar's Signa	dature	Spar	K								

State of Maryland / Department of Health and Mental Hygiene

			Oldio of Maryla		tificate o	f Death	Re	g. No.	n.	22010
		1. Decedent's Name (First, Middle, Last)					2. Date of Deeth Month	Dey	Year	3. Time of Death
	ysician Medical	Eugene E. Connor					Septem			08:20 PM
	caminer	4a Fecility Neme (If not institution, give s	street end number)			4b. City, Town, or	Location of Death	4c. County	of Deeth	
		Allegany Nursing Hom	ne			Cumberle		Alleg	any	
	neral ector	5. Social Security Number 6. Sex 212-24-2216	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Day					ace (State or Foreig ry) yland
p .		Usuel Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	cation				10	Dd. Inside City Limits
e Maryla	thed at	Maryland Allega		ostburg						1 Yes 2 □ No
th with th	al Director	10e. Street end Number 129 Mou	unt Pleasant Stre	et	10f. Zip Code			og. Citizen of W	/hat Count	ry?
d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	Examiner must be notified at by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Yeer or Dates:		Vas Decedent o Yes, specify Cu □ Yes 2 N	f Hispanic Origin? (Suben, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - America k, White, e	etc.
nin 72 hours n "neturel".		15. Decedent's Educ (Specify only highest grede	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occ kind of work dor DO NOT use reti	upation se during most of wo red)	rking	6b. Kind of Bu	siness/Ind	ustry
filed within Hygiene.	E E	Elementary/Secondary (0-12)	College (1-401 5+)	Unkı	nown			Dairy		
should be filed of Mental Hygi marked other	event, Be C	17. Fether's Neme (First, Middle, Lest)				18. Mother's Na	me (First, Middle, M	laiden Surnam	е)	
ould be Mental	ار ار	Robert E. Connor				Agnes I	Murphy			
and 2 should saith and Men	E .	19a. Informant's Name/Relationship (Ty) Rebecco Shorb	ne, Print) Niece		g Address <i>(Stre</i> Hillside Circ	le	ural Route Number, I Urmont		State, Zip	Code) 21788-
of Hea	y or other	20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Place of Dispo- cemetery, crem aint Michael	natory or other p		Date 2	Oc. Location -	City or Tov	
parmit. Page Department of	any injury ance.	21. Signature of Funeral Service License	Dung E		. Name and Add	·	Frost Ave., f	rostburg	, MD 2	21532
	ets.	23a. Par Enter the diseese, or compti	cations that caused the de le cause on each line.	ath. Do not ente	er the mode of d	ying, such as cardia	c or respiratory arre	st,		Approximate tnterval Between Onset and Death
Physi /Med Exam	dical niner	Immediate Cause (Final disease or condition resulting in death) a	BACTERIA Due to	(or as a conseq	EU MO Number of):	(A-				4 DAYS
law requiras that the death certificate be executed as been stoned by the attending physician and	as the burial-transit	Sequentially tist conditions, if eny, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		(or as a conseq						
eath certif	or usa									
hat the de	detached y	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying cause	given in Part I.	23b. Did tol		tribute to 3 □ Prob	the cause of deat
aw requiras t							24a. Was ar perform		ava	re autopsy findings illable prior to npletion of cause death?
0 -	раде	-					†∐¥e	5 202No	1 🗆	Yes 2□ No
	director, page	25. Was case referred to medical				26. Place of De	ath (Check only one)		
2 .0	To E	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2	☐ ER/Outpatien	t 3□ DOA	Other: 4 Nursing	Home 5□ Reside	nce 6 🗆 Othe	er (Specify)
Attanding Physic death.	70	27. Manner of Death 1 6 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	V	jury et /ork? □ Yes 2 □ No	28d. Describe ho	w injury occurr	ed	
To the Hospital or Attanding F within 24 hours after death.	Completely filled in by the funeral	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	eet and Numb , State)	er or Rura	l Route Number,					
Hospit 1 24 hour	plately filli edical	29a. Certifier to Certifying Physics (Check only one)	niclan: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation end/or inv	occurred at the vestigation, in m	time, date and plac y opinion, death occ	e, and due to the ce urred at the time, da	use(s) and ma ite and place, a	nner as stand due to	ated. the cause(s)
of thir	omp A	29b. Signature and title of certifier	0 /	1	29c. Lice	nse number	29	d. Date signed	(Month, L	Day, Year)
	1	Moleusticus 30. Neme end address of person who co	1. Vaner	L (Tunc	D-	148 65	Medical 13	SEPT.	307	- 2004
ML	1	Robustiano J.	Barrera 32/Registrar's Sig	M, D. //	Memorial	Hospital	Medical B	oldy, Cin	inbei	land, MD
	State	31. Dete filed (Month, Day, Year)	22 negistrar s sig	S	Spark					

DHMH 16 Rev 6/95

		-	For State Registrar	State of Ma	•	,	rtment of He		Mental Hy	giene Reg. No	nol.	32914
			Decedent's Name (First, Middle, Last	·)					2. Date of De	aath		3. Time of Death
	Physicia		Alvin	R	ichard		Cor	ner	Month 09 -	28		10:21 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. Cily, Town, or	Location of Dea	th	-	. County of Deat	
			SACRED HEART	HOSF	1 TAL		CUMB	ERLAN	D		ALLEGA	TNY
	Funeral		5. Social Security Number 6. Se	17 _	(In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	rth ay, Year,	9. Birti	nplace (State or Foreign
	Director		214-36-6/83	MM 2□F 6	5 Yı	rs.			(Month, Di 03/19)	/193	9 Mai	y land
	and *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	eation					10d. Inside City Limits
	l sho	5	MD Alleg		* '		berland					1 X Yes 2 □ No
	28a-1	Director	10e. Street and Number				10f. Zip Code		1	10a. Ci	itizen of What Co	untry?
	with Ba or	<u></u>	305 Dorn Avenu	•			,	502			USA	,
	ns 23	by Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of His Yes, specify Cubar		Specify Yes or No	0-	14. Race - Ame	rican Indian,
10	r Iter	ᆵ	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🛣 No	,				rto Rican, etc.)		Black, White	e, etc.
8	al', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 21X No	Specify:			Specify: V	Nhite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-f show sht, the Medical Exertifier must be rediffed at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. [Deced Give	ent's Usual Occupa	tion uring most of we	orkina	16b. K	(ind of Business/l	ndustry
21	ithin 19.	npie	Elementary/Secondary (0-12)	College (1-4or 5+	-)		kind of work done di OO NOT use retired)		3	171	-11-	Foods
2	ed wygier ygier yer th	S	12			1	oreman	40.14.15.1.41	/=:		olesale	roous
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumetic event, the Medical Exertiser mast by notified at	o Be	17. Father's Name (First, Middle, Last) Leonard	Well	ington	C	onner	Mamie	ıme (First, Middle	_	abeth	Burkett
ary	2 should be f and Mental b is marked of reumetic eve	2	19a. Informant's Name/Relationship (7			Mailin	g Address (Street a	nd Number or F	Rural Route Numb	er, City	or Town, State, Z	lip Code)
	1 and 2 Health a tem 27 is		Mary F. Conner /	wife			Dorn Ave	enue, Cu	ımberlan	d, M	D 21502	2
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	20b. Place of Cometery,	Dispos , <i>crem</i>	sition (Name of atory or other place)	Date	20c. L	ocation - City or	Town, State
Ĕ	I T T T		*4 Donation State (Specify		Cumber		d Cremato				mberland	
alt	permit. Pages Department of Importent: If it any injury or c		21. Signature of Funeral Service Licens	500		22				-		Home, P.A.
ш	20239		Tolut C	(lelle	ne		404 Decat				and, MD	21502
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused to the cause on each line	the death. Do no e.	ot ente	- , ,		ic or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a FUlm	01914	t	m5010	15				3 hours
E	/Medical Examiner		resulting in dealth)	Due to (or as a	consequence):						
		<u>-</u>	Sequentially list conditions,	b. Due to (or as a	consequence of	f):						
, —	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,						
Ć	be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of	f):						
8760,	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d								
9	tifical ng ph as th	0	15.55.11.5						· · · · · · · · · · · · · · · · · · ·			
Box	th cer endir r use	an/N	23b. was decedent pregnant	23c. If yes, outcome o		3□	Ectopic pregnancy				23d. Date of deli	
	he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at t 9☐ Unknown	ime of death		Other (specify)				Month	Day Year
P.0	that the de led by the a detached f	Phy	9 Unknown	and the state of the state of	h hi in i	ale	4-47	- In Donal	220 Did	tabasas.	una anatributa ta	the cause of death?
	uires that signed b	þ	Part II. Other significant conditions co	ontributing to death but	t not resulting in	me un	derlying cause give	n in Part I.	1 🗆		-	bably 4 Unknown
or o	w requir been si should	eted										
Records,	s law hes b e 2 s	Completed							24a. Was			topsy findings available completion of cause of
F	: The	3							1 Yes	2 No		21 No
Vital	ysicien: The law is certificate hes b director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	1/		Othe	r	eath (Check only			
of	Phy this	<u>۲</u>	Yes 2 No 27. Manner of Death	1 ☐ Inpatien			3 DOA 28c. Injury	4 Nursing	Home 5 Res	_		ify)
O	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Inj	ury	Work	? ′es 2 □ No	300. 50050		.,,	
Division of	Atten deat octor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	ry - At home, farr	m, stre	eet, factory, office					ral Route Number,
Ö	after Dire d in b	Certification;	4 Homicide	building, etc.	(Specify)				City or To	wn, Stati	Θ)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier Certifying Ph	/sician: To the best of iner: On the basis of								
	the H nin 24 the F nplete	Medicai	one)	and manner stat	ed.		oongation, in my op		anod at the time,	00.1 0	a piace, and dee	10 (116 Cause(s)
	To To	2	29b. Signature and title of certifier	onn mini-	unt	_	Zac. License	1947	9	29a. Da	'7(7 (7	, Day, Tear)
	6				10		100	- 1 6		(1	28120	, 0. 1
1	nds		30. Name and address of person who of	completed cause of de	ath (Item 23a) (T	ype, I	KMD (LL	alchi 1	Lumber	lau	d,MD	to the cause(s) Day, Year) OH 2(502
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	-	load	/				
	Registr	ar	SEP 2 9 200	+	N	,	japures					

		1	For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H			ene g. No.2 A A L	32915
		_	1. Decedent's Name (First, Middle, La	st)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Eugene_	Sta	nley	Clites		Octobe	r 1', 2004	7:50 A M
	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
			21501 Nationa		ge (In yrs. last birthday)	Flints	If Under 24 Hrs.	8. Date of Birth	Allega	
	Funeral Director			Sex 7. Ag IDXM 2□ F	80 Yrs.	Months Days	Hours Min.	(Month, Day, 07/01/1	<i>Year)</i> C 1924 Per	rthplace (State or Foreign ountry)
		E	Usual Residence of Decedent							
	nyland show		10a. State 10b. County Alle	gany	10c. City, Town or Lo	tstone				10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f s	Director			1 1 1 1 1			14	Og. Citizen of What C	
	with the		10e. Street and Number 21501 Nation	al Highway		10f. Zip Code 2 1 5	30		USA	ountry ?
	eath	Funeral	11. Marital Status	12. Was Decedent			lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
21215-0036	J within 72 hours after death with the Maryland Jiene 1 than "natural", or Items 23a or 28a-f show Ite Marical Evaniner must be ricitled at	þ	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 XYes 2 If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	White
9	72 hor	ted	15. Decedent's E (Specify only highest gr	ducation	(Give	dent's Usual Occup	during most of work	ring	16b. Kind of Busines	s/Industry
21	within i	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	<i>DO NOT u</i> se retired pervisor	d) "		Gas	
121	illed w Hygier other th		17. Father's Name (First, Middle, Las)	Su	pervisor	18. Mother's Nam	e (First, Middle, N		
and	e da ia b	o Be	Robert	Stanto	n	Clites	June		Estelle	Karnes
Maryland	d 2 should be the and Mental 7 is marked of traumatic ever	2	19a. Informant's Name/Relationship Helen L. Clites						City or Town, State,	Zip Code) 21530
	5 m ~ .	ŀ	20a. Method of Disposition 1 Å Burial 2 ☐ Cremation 3	Removal from State		matory or other plac	ce)		20c. Location - City o	
Baltimore,	permit. Pages 1 a Department of He- Important; if Item any injury or othe		* 4 □ Donation 8 □ Other (Spec 21. Signature of Fune al Service Lice			2. Name and Addre	-	ams Famil		Home, P.A.
8	8858		23a. Part1. Enter the disease, or cor	alan	d the death Consequent				erland, MI	21502 Approximate
	cate be executed // Medical Examiner ithe bruial-transit ithe bruial-transit	Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einer Uniderlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or a:	s a consequence of): s a consequence of):	Ala	zheim	as'		Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
	quires thal n signed t uld be det	2	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause gr	ven in Part I.			to the cause of death? Probably 4 □Unknown
Division of Vital Records,	The law requirence has been single 2 should I	Completed						24a. Was all autops perform	y prior to death?	autopsy findings available completion of cause of
ita	ian: rtifica ctor, p	BeC	25. Was case referred edical examiner?					th (Check only on		
× ×	Physician: this certificated director, is	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat					nce 6 Other (Sp	ecify)
n C	ling P	ion:	27. Manner Teath 1 ⊿ atural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) 28b. Time	Wo	ryat rk?]Yes 2 □No	28d. Describe no	w injury occurred	
ivisio	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of I	njury - At home, farm, s etc. (Specify)		7103 22.10	28f. Location (St. City or Town	reet and Number or I n. State)	Rural Route Number,
7	the Hospital hin 24 hours a the Funeral C mpletely filled	edicai Ce	29a. Certifier 1 Certifying F (Check only one)	Physician: To the bes	t of my knowledge, dea of examination and/or i	th occurred at the ti nvestigation, in my	me, date and place, opinion, death occur	, and due to the carred at the time, d	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
	To the Vithin 2 To the complet	Med	29b. Signature and title of certifier	A I I I I I I I I I I I I I I I I I I I	nuidu.	29c. Licens	se number	2	9d. Date signed (Mor	nth, Day, Year)
2	P TO DA		11	1/100	menon	D2:	2181		October 4	4, 2004
	has		30. Name and address of person win	//	death (Item 23a) (Type 925 Bisho		Drive, Cu	mberland	, MD 2150)2
3	St Regist	ate rar	31. Date filed (Month, Day, Year)		trar's Signature	Sparks	/			

			1 - For State Registrar	State of M		d / Depa		t of H	ealth a				004	32916		
			Decedent's Name (First, Middle, I	.ast)						T	2. Date of Dea	th		3. Time of Death		
	Physicia /Medic		Janet	Le	e		Came	ron			Month Octobe	Day	Year 2004	2:14 PM		
	Examin		4a. Fecility Name (If not institution, g	ive street and number)			4b. City,	Town, or	Location of	f Death			County of Death			
ı			5 Grandview C	Terrace				Cumb	erlan	d			Allega	ınv		
	Funeral					last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.				place (Stete or Foreign intry)		
	Director		213-40-3995	1 L M 2 L M	62	Yrs.	Wieliting	Duys	110010	.,,,,,,	07/19/	1942	Mary	land		
	and W		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y. Town or Lo	cation							10d. Inside City Limits		
	lanyti sho	5		gany			berl	and						1 ∑Yes 2 □ No		
	28a-i	Director	10e. Street and Number	67	<u> </u>		10f. Zip					0- 0:4:-	11/2-1-0-			
	with ta or	ā	5 Grandvie	w Terrace			101. 210	2150)2		'	USA	en of What Cou	intry:		
	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Items 23a or 28a-f show ant, the Medical Exercitratist be notified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V	Was Deced	dent of His	spanic Orio	in? (Spec	cify Yes or No-	1.	4. Race - Amer	ican Indian		
(0	riter	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀						Puèrto F	cify Yes or No- Rican, etc.)		Black, White			
8	urs a	by	3 ☐ Widowed 4 🏠 Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 🔼 No	Specify:				Specify: Wh	ite		
Ò	72 ho	Completed by	15. Decedent's (Specify only highest of			16a. Deced	16a. Decedent's Usual Occupation (Give kind of work done during most of working) life. DO NOT use retired)					16b. Kin	d of Business/Ir	ndustry		
2	thin 7	nple.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT US	se retired)	uning most	OF WORKIN	g					
2	ed wi	ပ္ပ	12			F	lomem						omemake	r		
2	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, La													
<u>yla</u>	ould Men arke	ဥ	Louis	Edgar		Hartur								eaver		
Maryland 21215-0036	2 sh and Is m	1	19a. Informant's Name/Relationship											p Code)		
	and lealth m 27 her t		Michael L. Camer	on / son	OOL D								WV 26722 DC. Location - City or Town, State			
0	ges 1 t of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	C	emetery, cren	natory or o	ther place								
Ē	men tant; jury		' 4 □ Donation 5 □ Other (Spec	cify)	Cu				-		4/2004			•		
Baltimore,	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Modical Exemiliater cast be notified at once.		21. Signature Fundal Service Licensee 22. Name and Address of Facility Adams Family Funeral Home 404 Decatur Street, Cumberland, MD 21.5											Home, P.A. 21502		
	Physician /Medical Examiner	liner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Heart Disease</u> Due to (or as a consequence of): Sequentially list conditions											Approximate Interval Between Onset and Death		
c 68760,	ortificate be executed ing physicien and e as the burial-transit	Medical Examiner	Due to (or as a consequence of):													
.O. Box	es that the death certilica igned by the atlending ph be detached for use as th	by Physician/Med	23c. If yes, outcome of pregnancy 1									23d. Date of delivery Month Day Year				
ords, P	The law requires that the ate has been signed by the bage 2 should be detache		Yes 2 No 3 P 24a. Was an autopsy performed? 24b. Were a prior to death?										the cause of death?			
Vital Records,		Comple										prior to co	opsy findings available ompletion of cause of			
/ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?								(Check only on					
οţ	Phys rthis ral dii	n: To	Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	iry	ER/Outpatien 28b. Time of Injury	-	8c. Injury	at		e Reside 8d. Describe ho			(y)		
ō	Attending r death. ector: After oy the fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	, , , ,	пцагу	М		es 2□N	ło						
Division	tel or Attendestis after deati	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of in	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town, S							reet and , State)	et and Number or Rural Route Number, State)			
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☑ Medicel Ex	Physicien: To the best aminer: On the basis o and manner st	f examinal	wledge, death tion and/or inv	occurred restigation,	at the time, in my op	e, date and inion, death	place, ai	nd due to the ca	use(s) a ate and p	nd manner as s place, and due t	stated. o the cause(s)		
	To the h within 2- To the complet	Ž	29b. Signature and title of certifier	/)			290	. License	number		25	d. Date	signed (Month,	Day, Year)		
	2		MAT Y	Show				D09	9157			Oct	ober 3,	2004		
,			30. Name and address of person wh	o completed cause of d	death (Item	23a) (Type,	Print)									
_	かん		Paul W. Sn	ow, M.D.,	124	West T	hird	Stre	et, C	Cumbe	rland,	MD	21502			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr			Spa	ch)	,				-			

			1- For Amend Item Registrar		land / Dep						ene	04	32917	
	Physici	an	1. Decedent's Name (First, Middle, Last,		Davis Sr Davis, S					Date of Death Month Oct. 1	Day	Year	3. Time of Death 2:00 P M	
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of I	Death			y of Death		
			3855 St. Lukes R		In at hinth da.	Sal	r 1 Year	If Under 24	4 Hre la	Data of Birth	Wicon		leas (State or Foreign	
	Funeral Director		240-31-106/	M 2□F 7. Age (In	yrs. last birthday Yrs.	Months			Min.	Date of Birth (Month, Day,			place (State or Foreign http: Cyland	
	and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation						1	Od. Inside City Limits	
	Maryl -1 sho	ğ	Md. Wicomic	20 8	Salisbur	У							1 ☐ Yes Ž☐ No	
	th the	Director	10e. Street and Number			10f. Zi	p Code			10	g. Citizen of	What Cour	ntry?	
	ath wi	rai	3855 St. Lukes Ro					1804			U.S			
936	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or Items 23e or 28e-f show other treumatic event, Ite Medical Examinations in the modified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Dece If Yes, spe 1 ☐ Yes		spanic Origir n, Mexican, i Specify:	n? (Specifi Puerto Ric	y Yes or No- can, etc.)		ce - Americ ick, White, fy: Wh			
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dec	edent's Usu	al Occupa	ation furing most o	of working		6b. Kind of E	Business/In	dustry	
21	Athin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT l</i> nercia					dverti	ising	Co.	
N	filed withi Hygiene. other than		17. Father's Name (First, Middle, Last)		СОШ	iercia	II AI		s Name (F	First, Middle, N			001	
and	d be f ental l ked o	To Be	Harry Davis							ghman I				
Maryland	2 should be and Mental Is marked o sumatic eve	F	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mai	ling Addres	s (Street a	and Number	or Rural A	Route Number,	City or Town	, State, Zip	Code)	
	1 and 2 Health a em 27 Is ither trei		Patricia Gauntt,			St.		s Rd.		isbury,				
o	Pages 1 nent of He nnt: If Iten iry or oth		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F	Removal from State	Ob. Place of Disp cemetery, cri	ematory or	other plac		Date		Oc. Location			
ti m	t. Pa ntmen rtent: njury		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 		Wicomico					04 8	Salisbu	ıry, I	Ma.	
Bal	permit. Pages Department of the Importent: If Ite any injury or of once.		21. Signature of Funeral Service Licens		1	Short 13 E.	Fune	s of Facility ral Ho e St.	ome Del	mar, DI	E 199	40		
	nysician		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the ne cause on each line.	+		de of dyin		ardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death	
1	/Medical Examiner	L .,	resulting in death) Sequentially list conditions,	Due to (or as a co	Fire 1	100	+	· (cre	<u>.</u>					
	nsit	cai Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or de a co	isoquarica (i).									
, C	te be executed ysician end ie burial-transit	Exa	resulting in death) Last	Due to (or as a co		\ (183	-			
68760,	cate be chysicia the but		•	a Chromic obstrative prima sause										
P.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician end bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3	l□Ectopic p i□ Other (s						ate of delive	ery Day Year	
rds, P	w requires that been signed b should be deta	ed by Pł	Part II. Other significant conditions co	1 ~	ot resulting in the	underlying	cause give	en in Part I.			acco use cor s 2 No		he cause of death?	
		Completed by							_	24a. Was ar autops perform 1 Yes 2	led?	Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings available impletion of cause of 2 No	
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of	Phys r this ral dir	۲: ا	1 ☐ Yes 2 ☐ No 27. Manner Death	1 ☐ Inpatient 28a. Date of Injury	2 ☐ ER/Outpation		28c. Injun Worl			5 Reside			(y)	
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Division	To the Hospitel or Attending Ph. within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29	c. License	a number		29	d. Date sign	ed (Month,	Day, Year)	
	8 <u>4 8 </u> 4		I Lay				DE	282	571	(mi)	10/	10	4	
	3		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	e, Print)	0	11 1	()	6	1010	01	100	
Q			Jock Simon	130	007	oast	1	17 (9)	Nuc.	5,00	Con	6.4	1 3,51/2	
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 4 20	32. Røgistrar's	Signature	4	ock	1		7			701015	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 3. Time of Death **Physician** Eloise Month Anita Eisenhower September 2004 8:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11627 Green Valley Rd. Union Bridge Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 8, 1941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 2 F 213-88-1361 Director Vrs Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23e or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Maryland Frederick Director Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11627 Green Valley Road 21791 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other then College (1-4or 5+) Office Supervisor County Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) r is marked of Ervin I. Eisenhower Anna Louise Kaldenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 McDowell Dr. Chester, SC 29706 Health aitem 27 is Erwin I. Eisenhower/brother 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot ang.e. 1 Burial 2 Coremation 3 Removal from State All County Cremation 9/29/2004 Sykesville, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Foneral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home attarine (Union Bridge, Md. 21791 6 E Broadway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ey6 ensive 114-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 ☐ Yes 2 10 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 → esidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No ို this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after d To the Funerel Direct completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) D146 26 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 56 10504 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Bleen & Sparke

		•	1 - State Registrar	State of	Maryland		artment of He tificate of D			ene 1. No. 0 0 4	32919		
1. Decedent's Name (First, Middle, La					RAB	INDI	1112		2. Date of Death Month OCTOBER	Day Year 02 2004	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give : HEBREW HOME OF GR	street and num	ber)		4b. City, Town, or ROCKVII	Location of Death		4c. County of Death	Υ		
	Funeral Director							If Under 24 Hrs.	8. Date of Birth Month, Day, Y OCT 21,		place (State or Foreign otry) LA		
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ROCKVILLE 10e. Street and Number 10g. C								10d. Inside City Limits 1		
36	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show fra Medical Examinar maal Le indiffied at	by Funeral Di	256 CONGRESSIONAL 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Give	12. Was Decedent Ever in U.S. 13. W			spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No-	NITED STATI 14. Race - Americ Black, White, Specify:	can Indian,		
Maryland 21215-0036	d within 72 hou giene. er then "natural i Ira Medical E.	Completed t	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation		(Give	tent's Usual Occupa kind of work done d OO NOT use retired) FESSOR	tion uring most of work	ing 16	EDUCATION			
yland	ould be fite Mental Hy, arked othe	9	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)										
Baltimore, Mary	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other then "natural; or Items 23a or 28a-f show many injury or other traumatic event, the Medical Examinar man Lea indifficial at Once.		19a. Informant's Name/Relationship (Ty DAVID FOX—RABINOVI 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 XF 4 □ Donaton 5 □ Other (Specify) 21. Signature of Funeral Service License	TZ -	State C6	9 ME1 ace of Disponmentery, crer CIONAL	LMARK COUR sition (Name of natory or other place CREMATORY ANZANSKY—	RT, GAITH	ERSBURG, Date 20 /2004 FA MEMORIAL	CHAPELS,	20878 own, State H, VIRGINIA		
	cate be executed /Medical /Medical Examiner and sthe burial-transit	Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, law, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
, P.O. Box 68760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23e. Did tobar	23d. Date of delivery Month Da 23e. Did tobacco use contribute to the c								
al Records,	The law ate has b page 2 sl	Completed	CHRONIC O	2 No 3 Prob 24b. Were auto prior to condeath? 1 Yes	opsy findings available impletion of cause of								
Division of Vital	tending Phys leath. tor: After this the funeral dii	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date o (Monti	h, Day Year) of Injury - At ho	ce 6 Other (Specify injury occurred	njury occurred						
ă	i i i i	- CG	29a. Certifier 1 Certifying Phy.	sician: To the	best of my know	vledge, deat	occurred at the tim	e, date and place,	City or Town, s	se(s) and manner as s	tated.		
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medic	29b. Signature and fittle of certifier	and mann	Leli	1	29c. License	number	29d	e and place, and due to t . Date signed (Month, $TOHEQ$ OZ	Day, Year)		
3	Sta Registi		30. Name and address of person who con Baybaya Kada 31. Date filed (Month, Day, Year)	WZUY 32/A	e of death (Item 6/2/ egistrar's Signat	ure G	1005E B	040, RC	OCKVILL	LE, HD	20852		

DHMH 17 Rev 1/2001

Registrar

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Event, or most be notified at Baltimore, Maryland 21215-0036 ŏ permit. Page Department of Important: If any injury or once.

> **Physician** /Medical Examiner

attending physician and for use as the burial-transit peen certificate has this After

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, fo the Hospital or Attending Physician:

11:50a M 29,2004 Fowler September Lois 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince Georges Laurel
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2 1 F 241-38-5136 Yrs. 73 June 10,1931 Winston Salem, N. C Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d, Inside City Limits Maryland | Prince Georges 1 ☑ Yes 2 ☐ No Laure 1 Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14200 Laurel Park Dr. 20707 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 之 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation 15 Decedent's Education 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerical Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julia Godball John Wardlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Hathaway Ct. Accokeek, Md. 20607 Iris F. Rosboro /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Oct.4,2004 Alexandria, Va. ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Alexander S. Pope Funeral Homes, Md: A 20747 01085 23a. Part. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Diabetes Mallitis Due to (or as a consequence of): Physician/Medical Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Degenerative Joint Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1X□ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Speyle MD AHENDING September 30, 2004 D42580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $^{\#13}$ Parmjit S. Aujla, M.D. 5632 Annapolis Rd. Bladensburg, Md. 20710 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 0 5 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

Year

Month



DHMH 17 Rev 1/2001

after death Director: /

within 24 hours a

To the Funeral C

completely filled

Box 68760. P.0. Records,

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 21 is marked other the any injury or other traumair. **Physician** Division of Vital Hospital or Attending Physician: within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and the of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 02, 2004 30. Name and addi no completed cau death (Item 23a) (Type, Print) nds 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 0 4 2004 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Annie Elizabeth Freeman September 28; 2004 22:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1□M 2\ F Director 219-40-5360 86 Yrs Nov. 1917 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or Items 23a or 28a-f show 1 XYes 2 ☐ No Completed by Funeral Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1184 Tyler Avenue 21403 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if item 27 Ia marked other than "natural", or Item any injury or other traumatic event, the Mudical Experiment once. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward Robinson Etta Cleo Blanche Weaver ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1184 Tyler Avenue Samuel Elmer Freeman / Husband Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Hillcrest Mem. Gardens 10/1/2004 Annapolis, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Artens disease or condition Corollar lyen resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9☐ Unknown 9 Unknown s been signed I should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Gastrie Ulcer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an page 2 autopsy performed? (es 2/2)No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No the 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 124800 -M1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson UD. 31. Date filed (Month, Day, Year) 32. R trar's Signature State SED 3 0 2004

DHMH 17 Rev 1/2001

Registrar

		•	1 - For State Registrar	e of Maryland /		artment rtificate				iene eg. No. () () ()	32924		
	Physici	an	Decedent's Name (First, Middle, Last) TTTTTTAN CT	REENSPAN					2. Date of Dea Month	th Day Year			
	/Medic	al	4a. Facility Name (If not institution, give street as		own, or L	ocation of Dea	OCTOBER	4c. County of De					
	Exami		SHADY GROVE ADVENT	MONTGOMI	ERY								
	Funeral Director		5. Social Security Number 157-12-9570 Usual Residence of Decedent	7. Age (In yrs. last I	Yrs.	If Under 1 Months	Year Days	If Under 24 Hr Hours Mir	. (Month, Day	8. Date of Birth (Month, Day, Year) 9. Birthpla Country FEB. 19, 1917 NEW			
	land	}		10d. Inside City Limits									
	Marylan e-f show	tor	MARYLAND MONTGOMERY	СН	EVY	CHASE					1 XYes 2 No		
336	with the	Il Direc	2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 UNITED STATES OF AM										
	72 hours after death with the Maryland neturel', or items 23a or 28e-1 show disal Exandrat must be profitted at	by Funeral Director	1 Never Married 2 Married 1 If Ye	s Decedent Ever in U.S. ed Forces? Yes 24 No ss, Give r or Dates:	1	Was Decede If Yes, specif			e - American Indian, ck, White, etc. WHITE				
2-00	72 hou		15. Decedent's Education (Specify only highest grade comp.		(Give	dent's Usual	done du	ion uring most of w	orkina	16b. Kind of Business/Industry			
21215-0036	d within jiene.	Completed		ege (1-4or 5+)	life.	DO NOT use EMAKET	retired)			OWN HOM	Ε		
Maryland 2	2 should be filed and Mental Hygir is marked other eumatic event, II.	To Be C	17. Father's Name (First, Middle, Last) JOSEPH AARON GUNSB	ERG			1		ame (First, Middle, I	Maiden Sumame)			
lary	2 should I and Men is marke	J	19a. Informant's Name/Relationship (Type, Prin							r, City or Town, State,			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-1 show Importent: If item 27 is marked other than "neturel", or items 23a or 28e-1 show importent or other treumatic event, the Medical Examinational be notified at once.		ROBERT M. GREENSPAN -			INNAKE sition (Name		ILL LAN		MASS 0204.			
nor			1 XBurial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	ceme	tery, crei	natory or oth ION CEN	er place)	RY 10/		ADELPHI,			
Baltimore,	permit. F Departme Importer any injur		21. Signature of Funeral Service Licensee							CHAPEL,			
	23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions									est,	Approximate Interval Between Onset and Death		
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decodent pregnant in the past 12 months?	ue to (or as a consequence of oregnancy clive birth 2 Petal dea	ath 3[∃Ectopic pre				23d. Date of d	elivery Day Year		
P.O. E	that the death cer ed by the attendin detached for use	hysici	1 Vac 2 VINa 4L	Pregnant at time of death Unknown	5[Other (spe	cify)			Month Day Year			
	law requires that the death as been signed by the atter 2 should be detached for t	þ	Part II. Other significant conditions contributing Dementia	g to death but not resulting	g in the u	inderlying car	use giver	n in Part I.			to the cause of death?		
Vital Records,	o - 9	Completed	Anaenia Bolateral Ver	ious Three	n. 10	oembo	lión	1 100	24a. Was a autops perform	sy prior to			
/ital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- CM		26. Place of D	eath (Check only or	-			
of	d is	To To	1 tes 2 kino	1 patient 2 EHV	b. Time o	nt 3□ DOA of 28	c. Injury a	at Nulsing		ence 6 □Other (Sp ow injury occurred	ecify)		
ion	Attending F r death. sctor: After by the funer	atlo	2 Accident investigation		Injury	М		es 2□No					
Division	el or Atto s after de il Directo d in by ti	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, building, etc. (Specify)	, farm, st	reet, factory,	office		28f. Location (Si City or Town	treet and Number or I n, State)	Rural Route Number,		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier Certifying Physicien: (Check only one) 2 Medical Exeminer: Or an	To the best of my knowled the basis of examination d manner stated.	dge, deat and/or in	h occurred a vestigation, i	t the time	e, date and plan nion, death oc	ce, and due to the courred at the time, d	ause(s) and manner a late and place, and di	as stated. ue to the cause(s)		
	To the within To the comple	Me	29b. Signature and title of certifier	00			License	-		9d. Date signed (Mor	nth, Day, Year)		
	15		mendl	well	MI)])3	82E	, 2	oct 1	, 2004.		
S _			30. Name and address of person who complete	RATTA.	241	Print)	240	archi	2 3 LVD S	iute 330	Rochrele		
	St Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 4 2004	32. Registrar's Signature	9	Spa	els	/					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

gan	y co.		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 1 2 2 2 2 5
	Physici		1. Decedent's Name (First, Middle, Last) CHRISTINA R. GAINER 2. Date of Death Month Day Year SEPT. 28, 2004 1:20 A.M.
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) COODWILL -FO
	anyland show	7	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD ALLEGANY CUMBERLAND 12 Yes 2 □ No
	with the Marylar s or 28a-f show be notified at	Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
20	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show he Modical Examiner must be roullied at	by Funeral Director	#1 BALTIMORE STREET 21502 U.S.A. 11. Marital Status 1 Never Married 2 Married
Maryland 21215-0020	within 72 hours ene. than "naturel", he Mudical Ex	Completed t	16a. Decedent's Usual Occupation (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired) 16b. Kind of Business/I
land 2	be filed al Hygi d other	o Be	17. Father's Name (First, Middle, Last) WILLIAM RUEHL 18. Mother's Name (First, Middle, Maiden Sumame) SOPHIA SCHNEIDER
	C & w	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE E. FRIEND/NIECE 880 MONTANA LANE, OAKLAND, MD 21550
Baltimore,	Pages 1 ent of He nt: If iten y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, crematory or other place) GREENMOUNT CEMETERY 10/1/2004 CUMBERLAND, MD
Balt	permit. F Departme Importar any injur		21. Signature of Funeral Service Licensed 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502
	Physician /Medical Examiner	_	23a. Part1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Pheumonic Due to (or as a consequence of):
x 68760,	Attending Physician: The law requires that the death certificate be executed ar death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):
O. Box	ne death certif the attending thed for use a	ysician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?
scords, P.O.	tw requires that the dess been signed by the a	Completed by Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atheroscleretic Cordiovoscular disease demon tie 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
tal Re	ysician: The law is certificate has director, page 2	Be Com	1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)
Division of Vital Records,	To the Hospital or Attending Physicis within 24 hours after death. To the Funerel Director: After this cert completely filled in by the funeral direct	Certification: To B	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be
Divi	pital or At ours after of arel Direc	l Certif	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	(Check only one) Check only one Check one Ch
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) We Her K. Noumann MD. PUBOX 247 Accident MD 21520
^	MUS		
9	Sta Registr		31. Date filed (Month, Day, Year) OC 1 0 1 2004 32. Registrar's Signature Spark

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3, 2004 1:30 P October <u>Treber Wonda Green</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 813 East Old Philadelphia Road E1kton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 1 X M 2 □ F 77 Director May 28, 233 40 5260 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Cecil E1kton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 813 East Old Philadelphia Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. hours after 1 ☐ Yes **※XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Assembly Line Worker Chrysler permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked of the any Injury or othar traumeth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martha Sophrona Stanley Richard Lee Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita June Green/Wife 813 East Old Philadelphia Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Bank Cemetery Oct. 7,2004 Rising Sun, Maryland ⁴ 4 □ Donation 5 Other (Specify) Ineral Service License 22. Name and Address of Facility Crouch Funeral Home 21. Signatur 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIA Physician /Medical Due to (or as a consequence of): Examiner CELL LUNG CARCINGMA NONSMALL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician lan/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Physicia 4 Pregnant at time of death 5 Other (specify) Records, P.O. the th detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 X Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division or Attending 5 Pending investigation 1 Natural after death. 2 □ No 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To tha Funaral C the Hospital Exiting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) BD 7464504 OC TOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ThOMAS M. DUGGAN 207 NORTH STREET REKTON MO 21921 39. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2004 Registrar OCT

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 22007 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 25, 2004 Physician 2:30 PM Pamela Gagnon Palmer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1689 Flint Rock Court Finksburg Carroll 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🗙 F Vre March 4, 1947 456-76-0805 Amarillo. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🖾 No Director Carroll Finksburg 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? death Funeral 21048 1689 Flint Rock 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 **is marked other than "n**a College (1-4or 5+) Mechanicsville Elementary/Secondary (0-12) Special Education Assistant Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Palmer Dorothy June McMurtry Ray ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other traum once. Richard P. Gagnon Husband 1689 Flint Rock Court, Finksburg, MD 21048 09/26/2004 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Winfield, MD South Carroll Cremations 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Service 22. Name and Address of Facility 412 Washington Rd. Pritts Funeral Home & Chapel Westminster, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ETASTATIC 12 45 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number 29b. Signatu MI 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEST MINSTER MUS 555 S. CENTER 35 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar Blown It Spark

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 04 **Physician** 1145 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MERCY MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12–12–1934 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 X F Yrs Director 235-50-2712 69 West Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d, Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 1706 Midland Rd. 21037 or itams 23a USA Funeral permit. Pagas 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural!" or hard any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXVo White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lowel W. Payne Nelly Frame 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1706 Midland Rd., Edgewater, MD 21037 Gerald D. Gill/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery | 10-1-04 Brentwood, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit law requires that the death certificate be executed the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown cate has been signed by i page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 1 ☐ Yes 2X No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation Director: 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funaral Dire 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatine and title of certified ō who completed cause of death (Item 23a) (Type, Print)

W 50 ST. PALP 30. Name a BAUTIMORES, MO State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2020 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 834 (October **Physician** MAR 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAICKI Wiramica ROGIONM SAUSBUR If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 200 F -42-4359 Yrs. Director - 12 -Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at SALISBUR 1 Yes 2 □ No Director WICOMICO 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 3234 21804 SA OHNSON Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permil. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify BLACK Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL EDWARDINEUT 12 DERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be STEWART WILLIE ADEL CYDE TATTIE ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32343 JANSON ROAD - SALBBURY MD. 21804
ca of Disposition (Name of Date 20c. Location - City or Town, State DRAYTON - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Oremation 3 Removal from State 4 Donation 5 Other (Specify) HEBRON, MD. SPRINGHILL 10/9/04 21. Signature of Juneral Service Licensee 22. Name and Address of Facility BENDIE 917-WISABELLA ST. SALISBURY, MD. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Stubic Immediate Cause (Final disease or condition resulting in death) meta morcubic Physician 2 MD /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9□ Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 🗷 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 🗌 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home ္ 5 Residence 6 Other (Specify) this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Director: After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funerai C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 m.b JANET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 4 2004 Registrar

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 Year October 5, **Physician** Harvey Hawthorne 1:05 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mt. Airy
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days | Hours | Min. | Month, Day, Year)
June 11, 1920 13518 Old National Pike Frederick 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) 1₩ 2□F 577-16-5948 84 Yrs Washington, DC Director Usual Residence of Decedent the Maryland 10a. State 10c. City Town or Location 10b. County 10d. Inside City Limits itam 27 la marked othar than "natural", or itams 23a or 28a-f show othar traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Frederick Maryland Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13518 Old National Pike 21771 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mentai Hygiene. Int: If itam 27 Ia marked othar than "natural", or Ital 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ò 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Wilmer Hawthorne, Sr. Nellie May Pearce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Helen Hawthorne/Wife</u> 13518 Old National Pike, Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. injury or Frederick Crematory 10/7/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 8 East Ridgeville Blvd., Mt. Airy, MD 21771 Part Anter the disease thock, or beart failure. I e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only ene cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Squamous Call
Due for as a consequence of): disease or condition resulting in death) /Medical Examiner C-1515 Due to (or as a seguence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit attending physician and Due to (or as a consequence of): P.O. Box 68760 ag Physician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 0 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: of or Attanding Fatter death.

I Diractor: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral L ** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 190205 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			For State Registrar AMEN#23a(C	State of N			artmen			and Mer		giene Reg. NG.		2500	2.0
			1. Decedent's Name (First, Middle) (Last)	D'IV,I'LL	<u></u>				2.	Date of De	ath	UU+	3. Time of D	Death-
	Physicia /Medic		Benjamin Frank	klin Hofheir	ner, J	r.				Se	Month ptemb	er 2	9, 2004	1:00	P ^M
	Examin		4a. Facility Name (If not institution	_	r) _				Location of	of Death			County of Deat		
			Manor Care Pot				Poto			0411-		1	ntgomer	-	
	Funeral Director		5. Social Security Number 225 • 09 • 0345	6. Sex 1 2 M 2 □ F	91	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min. No	Date of Bir (Month, Da V • 4,	19, Ye <i>ar)</i> 191	2 Vir	nplace (State or untry) ginia	Foreign
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					-		10d. Inside City	/ Limits
	Aaryla f sho	5				hesda							1X Yes 2 □ No		2 🗌 No
	28a-	rec	MD Montgo	лшету	Dec	nesua	10f. Zip	Code				10g. Citiz	zen of What Co	untry?	
	h with	<u>=</u>	6119 Ramsgate F	Road			208	316				U.S.	Α.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deprintment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itama 23a or 28a-f show amy injury pe other traumatic event, the Medical Exertil at most ke notified at any injury pe.	by Funeral Director	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	If Yes Give	? 9 No	If Yes, specify Cuban, Mexican, Puerto					Yes or No an, etc.)		4. Race - Ame Black, White Specify: Wh		
21215-0036	in 72 hou in "natura Medical E	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	r 5+)	16a. Dece (Give life.	dent's Usua kind of woi DO NOT us	al Occupa rk done d se retired	ation during mos.	t of working	king Automobil			е		
212	er than	Com		3 College (1-40	,	Co-Ov	mer						alershi	Þ	
Maryland	ould be fited Mental Hygi arked other atic event, I	To Be (17. Father's Name (First, Middle, Benjamin Frank		er.					er's Name <i>(F</i> Le Sch		, Maiden .	Sumame)		
ary	2 should and Men is marke sumatic	-	19a. Informant's Name/Relations			1	•						Town, State, 2	lip Code)	
	and 2 ealth m 27 in		Gil Hofheimer	- Son	anh B	-		-	Road	, Beth			20816	Town State	
Baltimore,	profit		20a. Method of Disposition 1X Burial 2 ☐ Cremation		Wasi	lace of Dispo emetery, creaning to g. Cem	matory or o n Heb	ther plac rew	θ)				cation - City or		
Iţ	rtmen rtant:		* 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Cong	g. Cem	etary	d Addres	C of Facilit	ot.3,2			ington 's Sons		
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ange.		Glegg &	. Ruet	3	5	130 W	isco	nsin	Ave.	N.W.,	Wash	s Sons	. 20016	
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause A each	line.	ati	ter the mod	e of dyin	g, such as	cardiac or re	espiratory a	rrest,		Approximate Interval Betw Onset and Do	eath
	/Medical Examiner			Due to (or	a /a conseq	(ence of):	iha	11/2	tur	M				YRC	
	l I Insit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Ceret	as a consist of al	vascu		dc	iden	t	-	_		VAC	
,092	ie be executed ysician and e buriat-transit	cai Exa	resulting in death) Last	Due to (or	as a consequ	uence of):		1						7100	
687	ficate phys s the			d.									1		
.O. Box	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	Completed by Physician/Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months?								23d. Date of delivery Month Day				ear
Δ.	requires that the een signed by th nould be detache	d by Pl											the cause of de		
Records,	aician: The law require certificate has been si irector, page 2 should b	Somplete									24a. Was auto perfo 1 🗆 Yes	psy ormed?	24b. Were au prior to death?	topsy findings a completion of car	vailable use of
Vital	ding Phyaician: n. After this certifica funeral director, t	Be	25. Was case referred to medica examiner?					0"		of Death (C					
of	Physic this c	2	1 ☐ Yes 2 ♣ No 27. Manner of Death	Hospital: 1 Inp		ER/Outpatie			4 23 140		5 🗌 Resi		Other (Spec	cify)	
u (ling h. After funer	tlon	1 XNatural 5 ☐ Pendi	28a. Date of I (Month, igation	Day Year)	Injury	M	8c. Injun Wor	k? Yes 2□		. 0030100	now injury	00001160		
Division	i or Attending after death. Diractor: Afte In by the fune	Certification:	3 ☐ Suicide 6 ☐ Could		Injury - At ho etc. (Specif	ome, tarm, st	reet, factory	y, office		28f	Location (City or To			ıral Route Numb)er,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medicel	ng Physicien: To the be Examiner: On the basis and manner	st of my kno s of examina stated.	wledge, deal	th occurred evestigation	at the tin	ne, date ar pini <i>o</i> n, dea	nd place, and ath occurred	I due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the comp	M	29b. Signature and title of certific	7					e number				e signed (Monti		
	D		10	Karin			Ĵ	25(79	2_		octo	BER,	,200	+
	(-		30. Name and address of person	who completed cause of	of death (Item	n 23a) (Туре • ЕД (Print)	IST	ON	DR.	Ro	CKI	ILLE	, 2001 , MD	
	St Regist	ate rar	31. Date filed (Month, Day, Year OCT 0 4	/ 02. 909	strar's Signa	ature A	Spo								
							-								

		4	For State Registrar	State of I	Maryland / Depa <i>Ce</i> a	artment of H rtificate of L			jiene 189. 18 0. () ()	32933
	Physicia	an	Decedent's Name (First, Middle, L IDA BELLE HIGG]					2. Date of Dea Month SEPTEMB	th Day Year SER 30 2004	3. Time of Death 10:11 P
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or FREDERIC	Location of Death		4c. County of Deal	th
	Funeral Director		5. Social Security Number 6. 214 14 4892	Sex 7. 1 □ M 2 🕱 F	Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov. 12	9. Bird 1920 Ma	thplace (State or Foreign buntry) aryland
	aryland show	70	Usual Residence of Decedent 10a. State 10b. County	- 7.7	10c. City, Town or Lo			-		10d. Inside City Limits 1 ☐ Yes 2 2 No
	or 28e-f	Director	Md. Carr 10e. Street and Number		Mt. Air	10f. Zip Code	01771	1	10g. Citizen of What Co	•
36	hours after death with the Maryland tural; or ttems 23a or 28e-f show al Ezan incrinust be notified at	by Funeral	7843 East Hill 11. Marital Status 1 Never Married 2 Married 3 D Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	™ No	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 1 Yo	21771 ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
Maryland 21215-0036	within 72 ane. than "na'	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work)	sing	16b. Kind of Business.	Industry Store
land 2	should be filed nd Mental Hygin marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Las. William E.	Wachter,			Jennie	В.	Maiden Sumame) Unglesbee	
	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship Carroll Higgins		on 1179	2 B Sier	Drive, N	1onrovia		70
Baltimore,	permit. Pages 1 as Department of Hea Importent: If item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Special Control of		Mt. Carr	matory or other place nel Cemete	ery 10/	² 05/04	Sunshine,	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lic	H.Be	race	Name and Address Muriel H P. O. Bo	0×5038	Laytons	ville, Md.	20882
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. PN	r as a consequence of):	Free (ms		от теарпатоту атт	1931,	Interval Between Onset and Death
8760,	ate be executed obysician and the burial-transit	If any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birt	nt at time of death 5	□Ectopic pregnancy □ Other (specify)	,		23d. Date of de Month	livery Day Year
Δ.	quires that n signed b uld be deta	ed by Pt	Part II. Other significant conditions	_	th but not resulting in the	underlying cause giv	en in Part I.		obacco use contribute t res 2 □ No 3 □ P	o the cause of death?
Records,		complete	antemia							utopsy findings available completion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only of		
Division of Vital	this al dii	ation: To	1 Yes 2 No 27. Mann Ceath 1 Natural 5 Pending 2 Accident investigal	28a. Date of	patient 2 ☐ ER/Outpatie Injury 28b. Time (Injury Injury	of 28c. Injur Wor	y at		lence 6 Other (Spenow injury occurred	ecity)
Divis	in the	Certification:	3 Suicide 6 Could no determine	289. Place C	of Injury - At home, larm, s g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
	Hospitel 24 hours a Funeral C	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the base aminer: On the base and manner	pest of my knowledge, dea sis of examination and/or i er stated.	th occurred at the tir nvestigation, in my o	me, date and place ppinion, death occu	, and due to the or rred at the time, or	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	6 X D 80	2000	29c. Licens	0 6 1 1 1	7	29d. Date signed (Mon	6
Q	ID		30. Name and address of person when	000	of death (Item 23a) (Type	, Print)			10-2-C	els po
∀ 7	St	ate	31. Date filed (Month, Day, Year)	7 M	gistrar's Signature	Sporks	WD 3	10514	Dani	eu, po
	Regist		OCT 04 20	104 5	eva 19	Sparks	1			

Please Type or Print in Black Indelible Ink. Ensure All Cop	pies Are Legible.
State of Maryland / Department of Health and Menta	l Hygiene
Cortificate of Dooth	- 9001

		_	For State Registrar		State of M	aryland		artment of rtificate o				Reg. No.	004	32934
	Physici /Medic		Dway		Last) Harriso	on					2. Date of Di Month Octob	eath Day er 01,	Year 2004	3. Time of Death
	Examin Funeral	er	3413 Dode 5. Social Security	ge Park Number	17€7M 2FTE	ge (In yrs. lasi	t birthday) Yrs.	4b. City, Towr Landov If Under 1 Ye Months Day	ver ar If L	Jnder 24 Hrs. burs Min.	8. Date of Bi	4c. C	ince Geo	Orge S lace (State or Foreign
	Director		577-04- Usual Residence			24	115.				August	19	Mary]	land
	show	ក	10a. State	10b. County	George's	10c. City, T	own or Lo						1	0d. Inside City Limits 1x☐ Yes 2 ☐ No
	28e-f	Director	10e. Street and No		ocorge 3		uando	10f. Zip Code	9			10a. Citize	n of What Coun	itry?
	3a or	Ö	7729 Ox	man Roa	d			2078				-	S.A.	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show enty injury or other treumatic event, the Medical Exertiral rutal by nuffiled at Once.	by Funeral	_	rried 2 Marrie	12. Was Decedent Armed Forces' ad 1 Yes 2 1 If Yes, Give Year or Dates:	7		Was Decedent of If Yes, specify C		nic Origin? (Specify:	ecify Yes or N Rican, etc.)		. Race - Americ Black, White, pecify: Bla	etc.
Maryland 21215-0036	hin 72 hou an "neture Medical E	Completed		, , -	s Education t grade completed) College (1-4or		(Give	dent's Usual Oc kind of work do DO NOT use ret	ne durino	g most of work	ing	16b. Kind	of Business/Ind	dustry
21	ed wit	Con	Elementary/Sec 10t					None				None		
land	uld be file fental Hy rked oth tic event	To Be	17. Father's Name David		.ast)					Mother's Name Ruth Ha		a, Maiden Si	лтате)	
Mary	d 2 shouth and he was the man		19a. Informant's Puth Ha	Name/Relationsh				ng Address (Stre						Code)
Baltimore,	iges 1 an of Heal		20a. Method of Di	sposition 2 Cremation	3 □ Removal from State	20b. Plac	e of Dispo	osition (Name of matory or other p	olace)		Date	20c. Loca	tion - City or To	
ij	artmer ortent injury		` 4 ☐ Donation 21. Signature of F	5 Other (Sp Funeral Service L		Resu		tion Ce 2. Name and Ad		10-9-			ton,Mary	
Ba	permi Depar Impor eny ir		23a Partt Enter) B	complications that cause		1	7474 Lan	dove	er Road	Landov	ver, M		
68760,	Physician be executed by physician and bursician and bursician and the burial-transit	edical Examiner	shock, or he immediate Cause disease or condit resulting in death Sequentially list of any, leading to cause. Enter Uncause, Disease ot that initiated even resulting in death	e (Final ion) conditions, immediate derlying or injury its	b. — Due to (or as		nce of):	VSHOT	_ W	DUND				Interval Between Onset and Death
Вох	Attending Physicien: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow	2 months? ! ☐ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	□Ectopic pregna □ Other (specify,				230	d. Date of delive	ry Day Year
ds, P	uires that signed b id be deta	d by Pł	Part II. Other sign	nificant conditio	ns contributing to death I	out not resulti	ng in the u	inderlying cause	given in	Part I.		tobacco use		e cause of death?
al Reco	i: The law req cate has beer r; page 2 shou	Completed											24b. Were auto prior to cor death? 1 🔊 es	psy findings available inpletion of cause of
Division of Vital Records, P.O.	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	lon; To Be	25. Was case reference? 1 XYes 2 27. Manner of De. 1 Natural	□ No ath 5 □ Pending	Hospital: 1 □ Inpati 28a. Date of Inj (Month, Da	ury 28	Bb. Time o	of 28c. ly	Other: 4 njury at Vork?			idence 6		At scene
Divisio	To the Hospitel or Attend within 24 hours after death To the Funeral Director; / completely filled in by the f	Certification;	2 Accident 3 Quicide 4 Homicide	investig 6 ☐ Could r determi	ot be	(tories)	12:0	eet, factory, offi		2 🗷 No	28f. Location City or To 3413 pc	wn State		I Route Number, Apt 103 ANDOUER, MD
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one)	1⊡ Certifyin 2 ⊠ Medical I	g Physician: To the best Examiner: On the basis of and manner s	of examination	edge, deat n and/or in	th occurred at the evestigation, in m	e time, da ny opinion	ate and place, n, death occurr	and due to the red at the time	cause(s) ar , date and pl	nd manner as st lace, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature an	nd title of certifier	c				ense nur			29d. Date s	signed (Month,	Day, Year)
,			20 Nome ===	metz	who completed severe of	death (Itam 0	30\ /T:	- 1	С.М.	Ε.		Octob	per 01,	2004
OR	(2)		A	NA K	WB10, MD		11	1 Penn :	Stre	et, Bal	Ltimore	, Mary	land 21	1201
	Sta Regist	ate	31. Date filed (Mo	onth, Day, Year)		rar's Signatur	-	and)				-		

		-	For State Registrar	State of Marylan		artment of rtificate of		-	giene	nnL	32935
			Decedent's Name (First, Middle, Last)	-				2. Date of De		Wasse.	3. Time of Death
	Physicia /Medic		Harry W. Hill					Septem	ber (30, Year 200	04 12:40 p ^M
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of De	eath	4c. C	ounty of Deat	h
			Anne Arundel Medic	al Center		Annapo1				ne Arur	
H	Funeral Director		212-12-5060	M 2□F 7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birl (Month, Da Oct. 3	th y, Year) 1, 19	18 Pen	nplace (State or Foreign untry) nsylvania
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	/anyl	5	Maryland Anne Arun	del Edo	gewater	r					1 ☐ Yes 2 No
	28e-	Director	10e. Street and Number	202	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code			10g. Citize	n of What Co	untry?
	death with the Maryland ms 23e or 28e-f ahow ringst be notified at	Ö	3705 Parke Drive			21037			U.S.A	Α.	
	death	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14	I. Race - Ame Black, White	
9	be filed within 72 hours after death with the Marylan tat Hygiene. Ad other than "natural", or items 23e or 28e-f ahow avant, the Medical Evarities mast be notified at		1 Never Married 2 Married	1 X Yes 2 ☐ No		1 ☐ Yes 2 🔯 No		0.10 1.100.17	1		hite
Ś	hours tural'	d by	3 Widowed 4 Divorced	Year or Dates: 1944		dent's Usual Occi	ination		16h Kind	d of Business/	
ဂ်	n 72 "nai	olete	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retir	e during most of ved)	working	IOD. IVIII	3 01 003111033	mousty
21215-0030	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Busin	ness Own	er		Autor	notive	Industry
	be filed htal Hygie od other avant, ti	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden S	umame)	
yland		To B	Harry Hill				Martha	Jeannett	e Har	nes	
E	s 1 and 2 should f Health and Men fam 27 la marke other traumatic		19a. Informant's Name/Relationship (Typ					Rural Route Numbe			
	1 and 2 Health am 27		Mary M. Hill - Wif					gewater,			
ore	Jes 1 of H ffitar or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emovai irom State		sition (Name of matory or other pl	h	Date		ation - City or	
Baltimore,	Pag tment tant:		* 4 □Donation 5 □Other (Specify)								Maryland
Pa	permit. Pages of Department of Himportant: If ite any injury or of once.		21. Signature of Funeral Service License	Dax Jan	ning	4739 Ba	ltimore		lyatts		MD 20781
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the deatle cause on each line.	h. Do not ent	er the mode of dy	ring, such as card	fiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
U	Physician		Immediate Cause (Final disease or condition resulting in death)	Respiratory	Fai	lure					hours
	/Medical Examiner		resulting in dealin)	Due to (or as a conseq	•						daus
		P.	Se uentially list conditions, if any, leading to immediate	Pneumoni Due to (ur as a conseq							days
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	COPD							years
'n	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
-	y s	Ical	d							-	
99	ertifica ing ph e as th	Med	IF FEMALE:					· · · · · · · · · · · · · · · · · · ·			
Box	eath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta	J death 3	Ectopic pregnan	су		23	ld. Date of deli Month	ivery Day Year
	Attanding Physician: The law requires that the death certifica r death. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	1 Yes 2 No	4□Pregnant at time of d 9□Unknown	eath 5L	Other (specify)					
٦.	w requires that the de been signed by the should be detached	/ Ph	Part II. Other significant conditions con		ulting in the u	nderlying cause g	oven in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?
ds	uires n sign lid be	d b	coronary arten	y disease				1100	Yes 2□	No 3□Pr	obabiy 4 []Unknown
Ö	s bee	olete	rheumatoid a	rthritis				24a. Was		24b. Were au	topsy findings available completion of cause of
He	nyaician: The law nis certificate has b I director, page 2 s	Completed						autop perfo1 ☐ Yes	ormed?	death?	_
ta	ian: rtifica stor, p	a	25. Was case referred to medical				26. Place of I	Death (Check only o			
>	Physici this ce al direc	To B	examiner? 1 ☐ Yes 2 📉 No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA O	ther: 4 🗆 Nursin	g Home 5 ☐ Resid	dence 6	□Other (Spec	cify)
0	ng Pl		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W		28d. Describe I	how injury	occurred	
Sio	tandi eath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				☐Yes 2☐No	GG4 Leasting (Carrantaria	Mumber of Di	und Claude Mumber
Division of Vital Records,	Hospital or Attanding F 24 hours after death. Funaral Director: After tely filled in by the funer	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, tarm, sti	reet, factory, office	9	City or Tol		Number or Hu	ral Route Number,
	To tha Mospital or Attanding Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Medical (29a. Certifier 12 Certifying Phys (Check only one)	sician: To the best of my knowner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date and play opinion, death of	ace, and due to the ccurred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	P. 10		29c. Lice	nse number			signed (Month	-
Ċ			> 1 Keece	uler mo	,	De	47311		1	0/1/0	4
6	Diva		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)			207	Ridge	ly Avenue
			Anne Arund	77.22.2		Suza	anne Nie	mala, M.D	• Ann	apolis	, MD 21401
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature						

			1 - State Registrar	State of Maryla	•	artment o			lental Hy	giene Reg. No.	nni.	32026
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
as a	Physici /Media		Dutchess Hopkins						Month 09	28	04	12:24 P.M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	m, or Loca	ation of Death		4c. Co	unty of Death	1
-46	ith Filippy (1997)		Prince Georges M			Cheve					nce Ge	orges
ĸ.	Funeral		5. Social Security Number 6. Security Number 1	M 2⊠F	s. last birthday) Yrs.	If Under 1 You Months Da		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	th i <i>y, Year)</i>	Cot	nplace (State or Foreign untry)
0 10	Director		579-56-5239 Usuel Residence of Decedent	61	113.				12 1	7 42	Wash	ington, D.
	yland		10a. State 10b. County		City, Town or Lo	cation						10d. Inside City Limits
	Mar a-f st	tor	MD Prince Ge	orges	Capitol	Height	s					1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Coo	de			10g. Citizen	of What Cou	untry?
	23a	rai	6902 Adel Street			207	43				USA	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 및 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was D <i>ecede</i> nt f Yes, specify (1 □ Yes 2 🔀		nic Origin? (Spe exican, Puerto pecify:	ecify Yes or No Rican, etc.)		Race - Amer Black, White ecify: Bla	, etc.
ğ	2 hou	ted	15. Decedent's Edu	cation		dent's Usual Oc				16b. Kind o	of Business/I	ndustry
215	thin 7 e. an "n Med	Completed	(Specify only highest grad	e completed) Coltege (1-4or 5+)	(Give	kind of work do DO NOT use re	one during stired)	g most of worki	ng			,
2	ed wi	Con		4 yrs.	Pens	ion Law	Spe	cialist		U.S.	Govern	ment
n D	ould be filed v Mental Hygie karked other I	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Name	(First, Middle	Maiden Sur	name)	
7	should nd Men marke umatic	2	Jimmy Wilson					Dorsey				
Maryland 21215-0036	d 2 sho h and 7 is mu traum		19a. Informant's Name/Relationship (Ty Angela Payne/Dau					lumber or Rura Terr.				ip Code)
	permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra once.		20a. Method of Disposition		. Place of Dispo	sition (Name o	f		Downe,		on - City or T	own State
altimore,	Pages net of int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☑ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren aryland	natory or other	place)	10-8-				own, otato
=	artme ortan injur		21. Signature of Funeral Service Licens					FacilitMArs		Laure:		Α.
Ä	permit. Departr Imports any inje		1 R Marcha	10-				. N.W.				
	Physician		23a. Part J Enior the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	eath. Do not ent	er the mode of						Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons		cardia_	-					hrs.
E.S.	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		d Cardi	Lomyo	pathy			2	2 yrs.
o`	cate be executed physicien and the burial-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
8760,	cate be	dical	C.	d								-
Box	nding puse as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg						23d	Date of deliv	I PLY
o.	that the death certifi ed by the attending detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregna Other (specify					Month	Day Year
rds, P	requires that been signed should be del	þ	Part II. Other significant conditions con	ntributing to death but not r	esulting in the ur	nderlying cause	given in l	Part I.		obacco use d Yes 2□No		the cause of death?
Records,	2 8 8	Completed								rmed?	Ib. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
Vital	ystcian: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?				26.	Place of Death		2)K] No	1 185	2 100
	Physic this ce al dire	101	1 Yes 2X No	lospital: 1 Inpatient 2	 ER/Outpatien	t 3 DOA	Other: 4	☐ Nursing Hor	ne 5 ☐ Resi	dence 6	Other (Speci	fy)
Division of	ding l		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work? 1 🗌 Yes	2	28d. Describe l			
Ď N	itel or Attender safter deatler al Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	et, factory, offi	ice	2	28f. Location (City or To	Street and Nu vn, State)	imber or Run	al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical	one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the estigation, in m	e time, da ny opinion	ite and place, a n, death occurre	and due to the ed at the time,	cause(s) and date and plac	manner as s ce, and due t	stated. o the cause(s)
1	To To Con	2	29b. Signature and title of certifier	Vat 1.3		29c. Lic	ense num	nber Dist	nct of	29d. Date sig		Day, Year)
/	1		" Michard J	reco, mi)		111	615	Glu	m5171	9/3	0/04	
K	(8)		30. Name and address of person who co		, , .	,						_
	Sta	to.	Richard J. Katz, 31. Date filed (Month, Day, Year)	MD. 2150 Po	ennsylva nature	anıa Av	e. N.	.W. Was	ningtor	, D.C.	2003	7
	Registi		OCT 0 5 2004	Blace &		le)						

			For State Registrar	State of M	Maryland /		artment of H				giene Reg. No. (101-	0000
			Decedent's Name (First, Middle	, Last)						2. Date of Dea	ath	1 2 3 1 1	3. Time of Death
	Physicia /Medic		Madeline I	ena Henders	shot				(Month October	Day 7	Year 2004	2:45 PM
	Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location o	of Death		4c. Co	unty of Death	
			Homewood Retir	ement Vill	age		William If Under 1 Year			0 = . (5:4		shingt	
	Funeral Director		5. Social Security Number	6. Sex 7 1 ☐ M 2 X F	Āge (In yrs. last 93	Yrs.	Months Days	Hours Hours	Min.	8. Date of Birtl (Month, Day July 2	7 1911	COL	place (State or Foreign intry)
			218-50-3011 Usual Residence of Decedent							July 2	/ 101	Penns	sylvania
	how i		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
	8a-1s	cto	Maryland WAshi	ngton	Cl	ear s	Spring						1 ☐ Yes 2X No
1	or 2	Dire	10e. Street and Number				10f. Zip Code				-	of What Cou	intry?
-	ia 23s	Funeral Director	13602 Rockdale	Rd 12. Was Decede	nt Ever in II S	12.1	2172		gin? (Sp	acifu Vas or No-		S.A. Race - Amer	ican Indian
_ 1	item mer	Ę.	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Force	s?	13.	Was Decedent of H f Yes, specify Cuba	an, Mexican	n, Puerto	Rican, etc.)	. 14.	Black, White	
	Exam	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date			1□Yes 2XINo	Specify:			Sp	ecify: Wh	ite
ם ה	ingo within 72 flours are death with the waryand. Hygione. ther than "natural", or itema 23a or 28a-f show out, the Madical Examiner must be notified at	Completed	15. Decedent (Specify only highes		1	6a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	t of work	ina	16b. Kind	of Business/Ir	ndustry
V	Mar.	np(Elementary/Secondary (0-12)	College (1-4d	or 5+)			d)		9			
7	tygler her ti		12 17. Father's Name (First, Middle, I	(apt)		Hc	memaker	19 Motho	or's Name	e (First, Middle,			Residence
= .	ntal F ed ot	Be		-			:				Waldell Su	mame)	
<u> </u>	permit. Pages I and 2 should be lited within 72 hours after death with the waryan beathern of the lith and Mental Hygione. Important: if item 27 is marked other than "natural; or itema 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at once.	ဥ	Alonza S. Barr. 19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street	_	ra S er or Rura		r, City or To	own, State, Zi	o Code)
	ulth ar 27 is r trau	1 9	Carl W. Henders	_	.11		Rockdal						
5	f Healitem		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of natory or other place			Date		ion - City or T	
	rage sent o nt: if ry or	- 3	1 urial 2 □ Cremation 1 Urial 2 □ Cremation 1 Urial Cremation 5 □ Other (Sp	3 □Removal from Sta pecify)	™ Warto	ordsk	ourg Pres.	by.	a+	11 04	Want	- walaki u	773
= 0	Departmen Important: any injury	1	21. Signature of Funeral Service I	icensee	0	22	. Name and Addre	ss of Facilit		11, 04 uglas A			eral Home
<u> </u>	88 5 8		1 Janu	10. Pau	lef Jr	1	331 East	ern B					ryland 21742
			23a. Part1 Enter the disease, or shock or heart failure. List			Do not ent							Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	-a CPCA	1/10/16	500	las asi	ido	7				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequen	ice of):	1/ /		7				
	Zammo	_	Sequentially list conditions,	b. Due to /or	as a consequen	5/1/	lapoh						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Bue to (or	as a consequen	100 01).							
_	al-tra	xar	that initiated events resulting in death) Last	c Due to (or	as a consequen	ice of):							
9	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edicai I		d									
9	cermicate nding phys use as the	led				dist			VV. OTHER				
ŏ	In cer lendir r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth	me of pregnancy 2 D Fetal de		Ectopic pregnancy	,			230	Date of deliv	,
ם ה	e death he atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of death		Other (specify)					Month	Day Year
ָר רַ י	requires that the		Part II. Other significant condition	ne contributing to doct	h but not regulting	ag in the u	adarhing gauga ga	on in Dart I		23a Did to	phacco use	contribute to	the cause of death?
S,	signe d be d	l by	Dictora 1	1.1 7.00	17	19 III 1110 U	nderlying oddae giv	Girian Caren		1 🗆 Y	_		
ecords	been	Completed	Stareter Met	in the	4/	- V	1.17.	/ 1	0/				· findings available
ě	s certificate has b lirector, page 2 sl	Id III	Potent Tox	aben th	age c	LM	1611	6 / y	14	24a. Was a autop perfor	rmed?	prior to co	opsy findings available ompletion of cause of
	n: Ir ficete or, pa	e Co	25. Was case referred o	010500	0525		_	00 Di		1 Tes	2 No	1 🗆 Yes	2 🗆 No
5	r this certific ral director,	0	examiner?	Hospital:	atient 2 TFR	/Outpatier	nt 3□ DOA Dth	00		me 5 ☐ Resid		Other (Speci	fy)
		급	27. Manner of Death	28a. Date of I		b. Time o				28d. Describe h			.,,,
0	Attending ir death. ector: Afte by the fune	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	Day (ear)	Injury		Yes 2	No				
UNISION	er de recto	ertification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of	Injury - At home etc. (Specify)	e, farm, str	eet, factory, office			28f. Location (S City or Tow	Street and N	umber or Rur	al Route Number,
ם	ira aft ral Di ied in	0											
	Hosp 14 hou Fune Fune	edical	(Check only 2 Medical	g Physician: To the be Examiner: On the basis	s of examination	dge, deat and/or in	n occurred at the tire vestigation, in my o	ne, date an pinion, dea	nd place, ith occurr	and due to the or red at the time, or	cause(s) and date and pla	d manner as a	stated. o the cause(s)
	To the Hospital of Attenti within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	one) 29b. Signature and title of certified	and manner	stated.		29c. Licens	e number			29d. Date.s	igned (Month,	Day, Year)
	- 3 - 8) ///	// //)		Di	261	POL	5 /	mx.	1010	the Dance
3				1//	Transfer of the Person						100	5	· CCDY
	,\ 9		30 N up and add as of parson	o pleted cause of	of death (Item 23	3a) (Tyne	Primo	1	1	1		^	1
3	V.V		3 N we and add s of person	c pleted cause of	of death (Item 23	Ba) (Type,	Prim	1	1641	esta	an M	DS C	742

				State of Maryland	d / Depa	artment of H	Health and	Mental Hy	.)		22020
			State Registrar		Cel	rtificate of	Deam	2. Date of Dea	Reg. No.	UUN	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last) Cicero Hancock					Month	Day	2004^{Year}	
	/Medic	al		and a subset		4h Chi Tours o	or Location of Dea			County of Dea	11:20 a ^M
	Examin	er	4a. Facility Name (If not institution, give st. Southern Marylar			Clinto		un		ince G	•
					ast birthdav)		If Under 24 Hr	s. 8. Date of Birt			
	Funeral Director		577-16-3091	M 2□ F 7. Age (In yrs. I	Yrs.	Months Days		Sept. 4	y, Year)	18 Mar	thplace (State or Foreign ountry) 'y Land
			Usual Residence of Decedent						<u>'</u>		
	how		10a. State 10b. County		, Town or Lo						10d. Inside City Limits
	e Ma	cto	Maryland Charle	es I	ndiar	Head					1 XYes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code				zen of What Co	ountry?
	ath w	-a	4805 Strauss Ave			206				.S.A.	
	er de	nue	T. Maria Claras	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		14. Race - Ame Black, Whi	
99	hours after death with the Maryland tural; or Itams 23a or 28a-f show Examiner must be notithed at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 MYes 2 □ No If Yes, Give Year or Dates:		1□Yes 2□ X o	Specify:			Specify: Wh	ite
Maryland 21215-0036	hou		15. Decedent's Educa		16a. Dece	dent's Usual Occup	pation	1	16b. Kir	nd of Business	
15	n "ng	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of word)	orking			
212	filed within 72 Hygiene. other than "nat ant, ire Madic	Completed	12	College (1-401-54)	Ele	ctricia	an		U.S.	. Gove	rnment
פ	be filed ital Hygi id other evant, I	ВеС	17. Father's Name (First, Middle, Last)					ame (First, Middle,			
<u>a</u>	should be filed within 72 hours after death with the Marylan and Mently light. Ind Mentla Hygiene. In marked other than "natural", or Itams 23a or 28a-f show marked other than "natural", or Itams 23a or 28a-f show umatic evant, Ita Madical Examinar count be notified at	To	Budd A. Hancock		,		Mary	E. Coo	ksey	Y	
<u>a</u>	2 sho and l is me		19a. Informant's Name/Relationship (Typ					Rural Route Numbe			
	rt 1		Betty E. Hancock	< Wife	4805	Straus	ss Ave.	, India			d.20640
ore	Pages 1 au nent of Hea ent: If item ury or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, cre	osition (Name of matory or other pla	Oct.			cation - City or	Point, Md.
Ē	tmen tent:		' 4 □ Donation 5 □ Other (Specify)	St	. Igr	atius (catholi				
Baltimore,	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Funeral Service License	M006	68 4	71111ams 270 HAW	Funer. vthorne	al Home Rd., I	, P. ndia	.A. an Hea	20640 d, Md.
			23a. Part 1. Ent of the lisease, or complic shock, or heart ailure. List only one	a has that c used the death	n. Do not en	ter the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ATRIA		1BRI	LLAT	700			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):						
Ħ	Examiner	,	Sequentially list conditions. b.								
	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the initial and conditions)	Due to (or as a consequ	uanea of):						
	and and I-tran	хаш	that initiated events c. resulting in death) Last	Due to (or as a consequence	neuce ot).						
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cai E									
687	icate phys s the	edic	d.								
×	certif nding ise a:	/Me	IF FEMALE: 23b, Was decedent pregnant	3c. If yes, outcome of pregna					2	23d. Date of de	livery
ă	death a atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		□Ectopic pregnanc □ Other (s <i>pecify</i>) _	у			Month	Day Year
P.O. Box	The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	Physician/M	9 Unknown	9□Unknown							
	w requires that been signed b should be delt	by P	Part II. Other significant conditions cont	tributing to death but not res	ulting in the u	inderlying cause gi	ven in Part I.	23e. Did t	obacco u	se contribute t	o the cause of death?
rd	equire en sig	ed	Ane	m15				10,	Yes 2	Z ^N 0 3□P	robably 4 Unknown
000	has be ge 2 sho	piet	V \(\alpha\)	sculpti	5			24a. Was		24b. Were a	utopsy findings available completion of cause of
Vital Records,		Completed							rmed?	death?	2 □ No
/ita	Physician: Th rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?			16.		eath (Check only o	nne)		
	hysi this c	2	1 1 Yes 2 200	ospital: 1 Anpatient 2		nt 3 L DOA		Home 5 Resid	_		ocity)
nc 0	ling F	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rryat ork?]Yes 2∐No	28d. Describe I	iow injur	y occurred	
Division of	Attanding in death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, st			28f. Location (Street and	d Number or R	ural Route Number,
Ω	tal or A	Certification;	4 Homicide determined	building, etc. (Specif	(y)			City or To	vn, State,)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely illed in by the funeral director.	edicai		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the within 2 To tha comple	Me	29b. Signature and title of certifier	8.11		29c. Licen	se number	C	29d. Dat	e signed (Mon	th, Day, Year)
•				400		D	4641	8	9-	30.0	4
1	Del.		30. Name and address of person who cor	mpleted cause of death (Item	n 23a) (Type	Print)		1201	o f	2	ND 20735
4	17075		31. Date filed (Month, Day, Year)	ratelmis), /5	01 54	OSCITT	> ra. (.111	ITON.	100 do 127
	Sta Regist		OCT 0 4	Patel Mrs 2004 32. Registrar's Signa	A CONTRACTOR OF THE PARTY OF TH	Goe Co					

			1 - For Stete Registrar	State of Marylar			of Health of Death		•	giene Reg. No. () () ()	32939
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Las Edna Hamil A. Facility Name (If not institution, give	ton		4b. City, T	own, or Location		2. Date of De Month Oct 5	Day Yea	12:15p ^M
	Funeral Director		92 Mullen A: 5. Social Security Number 6. S 214-28-6824 Usual Residence of Decedent		last birthday) Yrs.		Luke Year If Under Days Hours	Min.	8. Date of Bird (Month, Da June	y, Year)	any Birthplace (State or Foreign Country) Maryland
	h the Maryland r 28a-f show	Director	10a. State 10b. County Maryland Allection. Street and Number		ty, Town or Lo	10f. Zip C	ode			10g. Citizen of What	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Country?
920	be lited within 72 hours after death with the Maryland hat hygiene. od other then "neturel", or Items 23a or 28a-1 show event, the Medical Examiner must be routiled at	Funeral	92 Mullen Av 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I C . 12. Was Decedent Ever in U Armed Forces? 1	1		540 nt of Hispanic Or Cuban, Mexica		cify Yes or No- lican, etc.)	Specific	merican Indian,
21215-0036	liled within 72 ho Hygiene. other then "netusent, me Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2	lucation de completed) College (1-4or 5+)	(Give	DO NOT use	done during mos retired) nd Lom	b Ope	erato		
Maryland	should nd Mer marke umatic	To Be	17. Father's Name (First, Middle, Last) Charles H. 19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Е	ffie	Heste	Maiden Sumame) Cr er, City or Town, State	, Zip Code)
Baltimore, M	of Heal		Dorothy John 20a. Method of Disposition 1	Removal from State	Place of Dispo cemetery, crem	sition (Name natory or oth	er place)	Dā		WV. 2672 20c. Location - City	or Town, State
Baltir	permit. Page Department of Important: If any injury or		21. Signator of Funeral Service Licen	Hing.	22	Name and Boal 111 C		I Hor St, V	ne Wester	nport, M	nport, Md.
	Physician /Medical Examiner		23a. Part1. Enter the disages, of compositions shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	///	RCINO		8F V			rest,	Approximate Interval Between Onset and Death UNKNOWN
8760,	ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.							
P.O. Box 6	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3□	Ectopic preg Other (spec				23d. Date of d Month	elivery Day Year
	w requires lhat been signed b should be dete	þ	Part II. Other significent conditions co	ontributing to death but not res	ulting in the ur	nderlying cau	se given in Part I				to the cause of death? Probably 4 Minknown
Vital Records,		e Completed	25. Was case referred to medical				26. Place	of Death (24a. Was a autop perfor 1 Yes	sy prior to death? 2 No 1 Ye	
ot	ding Phys	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Othor	ursing Home	e 5 Resid	ence 6 Other (Sp. ow injury occurred	ecify)
Division	lospital or Attene hours after deatl unerel Director: sky filled in by the	il Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At his building, etc. (Specification: To the best of my known and the second	(y)				City or Tow		
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only 2 Medicel Exemone) 29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	ition and/or inv	estigation, in	my opinion, dea	ith occurred	at the time, c	date and place, and di 29d. Date signed (Mor	ie to the cause(s)
			30. Name and address of person who of	M.D.	n 23a) (Type, I		00596 Kalaupa	. /		10/	7/04
	Sta Registr		31. Date filed (Month, Day, Year)	32 Baginar's Signs	ature A	And	MARY	CAN.	1) Q	1502	3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 7 Pay **Physician** 2004ar 6:02 Lucius Chester Harris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. | 29,1940 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) 1**X**M 2□ F Director 64 183-32-0135 Alabama Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 27 is marked other then "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2X No St. Mary's California 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 22488 Wainwright Court 20619 filed within 72 hours after death United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1947-Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 1965 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Non-Commissioned Officer U.S. Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Hint: If item 27 Is marked of Lucius Chester Harris, Sr. Carrie Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653 item 27 other tra Mary Teresa Harris (WIFE) 21895 Pegg Road Apt. # 130 Lexington Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. 12, 2004 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crematory Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. David A. Goff MO1095 22955 Hollywood Rd. Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or compositions shock, or heart failure. List only of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician ARCINOMA OR CoMO. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥Yes 2 □ No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 1)14285 10-7-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 1753 LEONARDTOWN 20650 WILLIAM D BOYDII

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

			For State Registrar	State of Ma	ıryland		artment rtificate			nd Me	• •	giene		L 3	291.1
	D1		1. Decedent's Name (First, Middle, Las	t)						2	2. Date of Dea Month			ear 3	. Time of Death
	Physicia /Medic		M	LLDRED	LOU	ISE]	HARI	€		SEPT.	24,			11:30A ^M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, T	Town, or	Location of	Death		4c.	County of		
			2211 GREEN MI	LL RD.					BURG			C	CARRO	OLL	
	Funeral Director		5. Social Security Number 6. S. 212-28-2564 1 Usual Residence of Decedent	PX 7. Age	7 4	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day 3 / 2 6 / 1	h y, <i>Year)</i> 930] [N	i. Birthplace Country) IARYL	(State or Foreign
	and **		10a. State 10b. County		10c. City	, Town or Lo	cation			·				10d.	Inside City Limits
	Mary 4 sho	ō	MD. CARROL	L	FIN	IKSBU	RG							İ	1 ☐ Yes 2 No
	28a	Funeral Director	10e. Street and Number		-		10f. Zip	Code			т.	10a. Citiz	en of Wh	at Country?)
	3a or	<u>ā</u>	2211 GREEN MIL	תק ז.				2104	Ω				USA		
	The 2	era	11. Marital Status	12. Was Decedent B	Ever in U.S	S. 13.				in? (Spec	ify Yes or No- ican, etc.)			American I	ndian,
٥	be filed within 72 hours after death with the Maryland Hygione. d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at	Fur	1 ☐ Never Married 2 XX Married	Armed Forces? 1 ☐ Yes 2 [X]N If Yes, Give	lo	1	lf Yes, speci 1 □ Yes 2			, Puerto Ri	ican, etc.)	1		White, etc.	
2-003e	raft,	d by	3 Widowed 4 Divorced	Year or Dates:			10 165 2	2 140	эрвспу.				<i>ървсп</i> у: 1	WHITI	Ε
ភ	72 h	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	dent's Usual kind of work	k done di	uring most	of working	,	16b. Kir	d of Busin	ness/indust	ry
2	fited within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	HOUS:	,				нОи	(EMA	KED	
2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	11/1			11000			r's Name /	First, Middle,			11111	
anc		Be		DERICK		CBAW	FORD	- 1			LLEN				
<u> </u>	should be ind Menta i marked umatic ev	2	19a. Informant's Name/Relationship		NID.						Route Numbe			ata Zin Co	dal
Maryland	d 2 s th ar treu		RAYMOND W. HARE		AND		1				,FINK				•
	tem 27		20a, Method of Disposition			lace of Dispo	sition (Nam	e of		Da	te	20c. Loc	cation - Ci	tv or Town.	State
Baltimore,	0 0		1 ☑ Buriat 2 ☐ Cremation 3 ☐ 14 ☐ Donation 6 ☐ Other (Spent)	Bemoval from State	EVER	emetery, crer GREEN	MEM	GAI.	RDENS	5 9/	27/04	FIN	IKSB	URG,	MD.
₫	permit. Pag Department Important: I any injury o once.		21. Signature of June at Service Licer								TCHER				
ä	Depa Impo any iu										ESTMI				21157
			23a. Part . Enter the disease, or com shock, or heart failure. List only	otications that caused one cause on each lin	the death									Ap	proximate ervat Between
1	Physician		Immediate Cause (Final disease or condition	a	Sev	rene	En	Λph	yse.	ma				Un	S 9 Cavs
١.	/Medical Examiner		resulting in death)	Due to (or as a	a consequ	uence of):		1	1						
н	LXammer	-	Sequentially list conditions,	b. Due to /or on	2 22220	ionos ofi									
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury	Due to (or as a	a consequ	derice or):									
_6	sate be executed hysician and the burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as a	a consequ	uence of);									<u>.</u>
8760	siciar siciar suri		(d											
687	ficate g phy s the	edlo		d											
ŏ	eath certific attending pl	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7e					2	3d. Date o	of delivery	
Ď.	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physiclan/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at			□Ectopic pre □ Other (spe						Month	n Day	y Year
o.	t the by th tache	hys	9 Unknown	9□ Unknown											
ທົ	res that the de signed by the a be detached f	by F	Part II. Other significant conditions of	ontributing to death bu	ut not resu	ulting in the u	inderlying ca	ause give	n in Part I.					ute to the ca	ause of death?
Records,	w require been si should t	ted									1 2	es 2]No 31	☐ Probably	4 □Unknown
ပ္ထ	law ra	Completed									24a. Was		24b. We	re autopsy	findings available ation of cause of
Ě	The late has	E									perto	rmed?	dea	ath? Yes 2	
Vita	sician: The law certificate has b irector, page 2 s	BeC	25. Was case referred to medical examiner?						26. Ptace	of Death (Check only o				
>	nysic nis ce direc	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatier	nt 3 DO	A Othe	r: 4 🗆 Nur	sing Hom	e 5 X Resid	lence 6	Other	(Specify)	
0	Attending Physician: It death. ector: After this certificity the funeral director,	i.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry v Year)	28b. Time o	f 28	Bc. tnjury Work	at ?	28	ld. Describe h	ow injury	occurred		
Sio	endl. Bath. or: A che fu	catle	2 Accident investigation				М	1 🗆 Y	'es 2□N	40					
Division of	i Sir de	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Ptace of Initional building, etc.			reet, factory,	, office		28	If. Location (S City or Tow	Street and vn, State)	l Number	o <i>r Rural R</i> o	oute Number,
	pitel ours eral filled		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my know	wladea daat	h conurad a	at the tim	o data and	t place, or	d due to the	201100(0)		or on state	-
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only 2 Medicel Exer	niner: On the basis of and manner sta	examinal	tion and/or in	vestigation,	in my op	inion, deat	h occurred	at the time,	date and	place, and	d due to the	cause(s)
	o the	Me	29b. Signature and title of certifier	4.4				. License				29d. Date	signed (Month, Day	, Year)
ř			hoel	MD				1) 5	120	35		Ser	+	24	200 x
	WIZ-		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type:	Print)		F =		-	-			, ,
	9		15(NU CHACIO		Ch		remy		Wer	tmer	Her	MI	211	57	
	. Sta	ite	31. Date filed (Month, Day, Year) SFP 2. 7	2004 32. Regular		ture	1	,							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2 Date of Death 3. Time of Death Haines Month **Physician** Year 30 m 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner If Under 1 Year Under 2 vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Months 216-05-Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-" any injury or other traumatic avarance. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD. CARROLL 1 ☐ Yes 2 No Director WESTMINSTER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 345 N. SPRINGDALE RD. 21158 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: by Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR SHOE FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOWARD FOREMAN FLORENCE MOSER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) WILLIAM E. PITTINGER -SON B29 N. SPRINGDALE RD., WESTMINSTER, MD. 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date TERMINIST 2 Cremation 3 Removal from State PINEY CREEK CHURCH CEM 9/28/04 TANEYTOWN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furnity Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) signed by the attend d be detached for us Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yee 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 Yes 2 No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ieral Director: After i filled in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. | Certifying Physicien: To the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number NJ 2 nd eddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

2004

			1 - For State Registrar		aryland / D	epartm		lealth and		giene Reg. No.	1. 3201.5
	Physici /Medic Examir	cai	Decedent's Name (First, Middle, La MARTHA 4a. Facility Name (If not institution, giv	L.		IARRI 4b. 0		r Location of Dear	2. Date of De Month Sept.	eath Day	
	Funeral Director		Salisbury Nursing 5. Social Security Number 6. S	and Rehab	Center e (In yrs. last birth	day) If U Mon	nder 1 Year	Salisbur If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	Wicomio	9. Birthplace (State or Foreig Country)
aryland 2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I am Andrald Hygiene. I amarkad other than "natural", or items 23a or 28a-f ehow aumatic evant, it a Medical Examinar must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County New Jersey Salem 10e. Street and Number 78 East Harmony S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest green before the secondary (0-12) 17. Father's Name (First, Middle, Last, Larry Pierce 19a. Informant's Name/Relationship (12. Was Decedent Armed Forces? 1	10c. City, Town Penns C Ever in U.S. No 16a. C (5+) ho	or Location Grove 13. Was D If Yes, 1 Yes Decedent's Give kind o diffe. DO NO USe Wi	Usual Occup f work done of use retired fe/hom	ispanic Origin? (Sun, Mexican, Puer Specify: ation during most of world) 18. Mother's Nat Mar	Specify Yes or Noto Rican, etc.) rking me (First, Middle tha Ridg ural Route Numb	10g. Citizen of Wh USA 14. Race- Black, Specify: 16b. Kind of Busi Domesti . Maiden Surmame) e Way er, City or Town, St	ate, Zip Code)
บ้	permit. Pages 1 and Depertment of Health Important: If Item 27 any Injury or other tr		Rev. Barbara Harm 20a. Method of Disposition 1 Burial 2	ryland 21811 20c. Location - City or Town, State Salem, New Jersey Road – Salisbury, MI 21801							
	cate be executed Medical Examiner the purial-transit	licai Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	/ LR.	mode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
.O. DOX 00	ath certifi ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectop	c pregnancy (specify)			23d. Date of Month	•
L (cp.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions o	ontributing to death b	ut not resulting in t	he underlyir	ng cause give	en in Part I.			ute to the cause of death?
al necolus,	yelcien: The law re is certificate has be director, page 2 sh	Completed					- /-			osy prio dea	re autopsy findings available or to completion of cause of th?
	elcian certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 ✓ 0	Hospital:			DOA Othe	· ·	ath (Check only o		
O HOISIAID	r Attending Phy er death. rector: After this by the funeral d	Certification; To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injui (Month, Day	/ Year) Inju	ne of ury M	28c. Injury Work	at	28d. Describe I	dence 6 Other (now injury occurred	(Specify) or Rural Route Number.
5	Hospital or 4 hours afte Funeral Dir ely filled in t		29a. Certifier 1 Certifying Ph	ysician: To the best of the basis of	examination and/	leath occur	red at the tim	e, date and place	City or Tow	vn, State)	or as stated
	To the within 2 To the Complet	Medical	29b. Signature and title of certifier 30. Name and address of person who	and manner sta	ited.		29c. License			29d. Date signed (A	
X.	Sta Registr		WILLIAM ROBINS, M 31. Date filed (Month, Day, Year) OCT 0 4 2	D 32. Registra	ar's Signature	4	200		ve.,Sal	sbury, M	d. 21804

DHMH 17 Rev 1/2001

MARTHA HARRIS

			For State Registrar	State of M	Maryland / Do	epartmer Certificat			and Me		jiene	nnl	3201.1.
			Decedent's Name (First, Middle, L.	ast)					1	2. Date of Dear	th	V	3. Time of Death
	Physicia /Medic		Velma E Johnso	n					C	ctober	Day	Year 2004	3:00 P M
}	Examin		4a. Facility Name (If not institution, g	ive street and number	r)	4b. City,	Town, or	Location o	of Death		4c.	County of Death	1
			Mariner Health C	are - Silv	ver Spring	g Sil	ver	Sprin	g		M.	Iontgome	ry
	Funeral		Social Security Number 6.		kge (In yrs. last birth	Months	r 1 Year Days	If Under 2 Hours	24 Hrs. 8	B. Date of Birth (Month, Day	Year)	9. Birth Con	nplace (State or Foreign
	Director]	263-05-1867	1□M 2⊠F	95 Yr	rs.			J	July 14			AL
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	sho	ò											1 Yes 2 □ No
	28a-1	Director	AL Mobil 10e. Street and Number	.e	Mobile	10f. Zij	Code .	-			IOn Citiz	zen of What Co	untry?
	a or					101. 24		-					,
	eath	Funerai	1600 Michigan A	12. Was Deceder		13. Was Dece	3660 dent of H		gin? (Spec	ifv Yes or No-	1	USA 4. Race - Amer	ican Indian,
	ter d	표	1 Never Married 2 Married	Armed Forces	5?				, Puerto R	ify Yes or No- ican, etc.)		Black, White	a, etc.
336	urs al	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 🗆 Yes	2 🔀 No	Specify:				Specify: B1	.ack
21215-0036	n 72 hours after death with the Maryland "netural", or Items 23a or 28a-f show ladical Examinat coust be notified at	Completed	15. Decedent's		16a. C	Decedent's Usu Give kind of wa	al Occup	ation	t of working	7	16b. Kir	nd of Business/I	ndustry
215	c * 6	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4o		life. DO NOT u	se retired	d)	O WOINING				
7	77 77 -	Son	12		Nu	rses Ai	de					spital	
БП	be filed tall Hygie d other if	Be	17. Father's Name (First, Middle, Lat	,						(First, Middle,		Sumame)	
yla		ို		gleton						na Nels			
Maryland	C/ 10 - 10		19a. Informant's Name/Relationship	(Type, Print)	19b. I	Mailing Address	s (Street	and Numbe	r or Rumai	Route Number	r, City or	Town, State, Z	ip Code)
	and lealth m 27 her tr		Johnnie L. Per	ry/Daughte	20b. Place of D			est D	rive.			ring. M	ID 20902
9	nent of He int: If Iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from Stat	cemetery	, crematory or	other plac	(e)	at 9	2004	200, Lo	cation - City or	TOWN, State
Ë	Pa tmen tant:		`4 □ Donation 5 □ Other (Spec		Oaklawr					,2004 _M	obil	e, AL	
Baltimore,	Depariment Department		21. Signifulire of Funeral Service Lic			22. Name a	nd Addre	ss of Facility	生ranc	cis J.	Coll	ins Fur	neral Home
	00 F 6 0		Michell	Jale	/	500 Un	iver	sity	Blvd.	W. Si	lver	Spring	, MD 20901
н			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly phelicause on each	line.	ot enter the mo	de of dyin	ig, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician	ê ă	Immediate Cause (Final disease or condition	_a. Sev	ere Coron	ary Ar	tery	Disea	ase				6 months
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of):							
		_	Sequentially list conditions,	b. Time to for a	as a consequence of	1	2000						
	per isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	230 (0) (0)	13 ta 0011304401100 01	,.							
	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):							
8760,	death certificate be executed e attending physician and of for use as the burial-transit												
687	ficate phys s the	Physiclan/Medical		d									
Box (leath certifica attending ph I for use as th	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							2	3d. Date of deli	very
ğ	eath atter	clai	in the past 12 months?		2 ☐ Fetal death at time of death	3 ☐ Ectopic p 5 ☐ Other (s		<u> </u>				Month	Day Year
o.	that the de sed by the a detached	hysi	9 Unknown	9□ Unknown									
σ.	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying	cause giv	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
Records,	quire n sig uld bu									1 🗆 Y	es 2	XNo 3 ☐ Pro	obably 4 Dunknown
00	w requir	jete								24a. Was a		24b. Were au	topsy findings available
	0 5 0	Completed								autops rohed	med?	death?	ompletion of cause of
Vital	ician: Th certificate rector, pag	O.	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only or		10100	20110
>	Physician: this certific ral director,	O.B	examiner? 1 ☐ Yes 2√J√No	Hospital: 1 ☐ Inpa	tient 2 ☐ ER/Outp	patient 3 D	OA Oth	er: XX Nu	rsing Hom	e 5 🗆 Resid	ence 6	Other (Spec	cify)
l of	g Ph er thi	n: T	27. Manner of Death	28a. Date of In	njury 28b. Ti Day Year) Inj	me of ury	28c. Injur Wor	y at		Bd. Describe h			
0	Attending In death. sctor: After by the funer	atio	1√Natural 5 Pending 2 Accident investigat	ion	,	M		Yes 2 🗆	No				
Division	or Attenceather deather Director:	Certification:	3 Suicide 6 Could not 4 Homicide determine	ad 286. Place of	Injury - At home, farr etc. (Specify)	n, street, factor	ry, office		28	Bf. Location (S City or Tow			ral Route Number,
Ö	tal or A	Cer											
	lospi hour			Physician: To the be aminer: On the basis									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific geompietely filled in by the funeral director.	Medical	one)	and manner									
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	1 1	1		ic. Licens D098:	e number 34				e signed <i>(Month</i> ber 2,	
	45)		· NH	overle	accor								
0			30. Name and address of person wh						3.6		000	0.5	
D			Barry Rosenbaum			. 4			, Mar	yland	208	95	
	Sta Regist	ate	31. Date filed (Month, Day, Year)		strar's Signature	1 60	acks	,					
	negist	ांचा	OCT 04 2	.004	/	//							

			1 - For State Registrar	State of Marylar			f Health and M of Death	ental Hygie	2001	32945
	Physici /Medio		1. Decedent's Name (First, Middle, Last Esther Louise Joh	inson				2. Date of Death Month Septembe:	r 30, 20	3. Time of Death 3:32 A M
	Examir	ier	4a. Facility Name (If not institution, give 401 Russell Avenue 5. Social Security Number 6. Se	e #806	last hirthday		n, or Location of Death aithersburg par If Under 24 Hrs.	9. Date of Righ	4c. County of Dec	ery
	Funeral Director		132-16-6572 Usual Residence of Decedent	□M 2KDF 84	Yrs.	Months Da	ys Hours Min.	8. Date of Birth (Month, Day, Ye Jan. 18,	1920 Nev	rthplace (State or Foreign Journal) W York
	Be-f show	Director	Md. 10b. County Md. Montgon		y, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	h with th	al Dire	10e. Street and Number 401 Russell Ave. #	⁴ 806		10f. Zip Coo	20877		Citizen of What C	•
900	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural" or items 23e or 28e-f show minor or other treumatic event, the Medical Ext. of the treumatic event, the Medical Ext. of the confined at ODGE.	d by Funeral	11. Marital Status 1 Xever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:	'	Was Decedent f Yes, specify (of Hispanic Origin? (Spe Cuban, Mexican, Puerto I No Specify:		14. Race - Am Black, Wh Specify: W	erican Indian, ite, etc.
Maryland 21215-0036	id within 72 h giene. er then "natu	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give		cupation one during most of workin tired) Religion	ng	. Kind of Business	s/industry
ryland	nould be file d Mental Hy narked othe natic evant,	To Be (17. Father's Name (First, Middle, Last) Dr. Frank Elmer J		100 14 11			lary Andre	₽W	
, Mai	and 2 sl salth an n 27 is r er treur		19a. Informant's Name/Relationship (T) Janet Merrick (N	iece)			eet and Number or Rura ourt Rockvil			Zip Code)
Baltimore,	ment of He lant: If iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	nge Ce	sition (Name or natory or other nter Ce	metery Oct.	4 , Or	•	nnecticut
Balt	permit Depart import any in		21. Signature of Funeral Service Licens	Day	1	0 East	^{ldress of Facility} DeV Deer Park D	rive Gait	1 Home hersburg	g,Md. 20877
8760,	Physician /Medical Examiner phural-transit	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aortic Sten Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	osis uence of): osis uence of):	er the mode of	dying, such as cardiac o	respiratory arrest,		Approximate Interval Between Onset and Death Years Years
.O. Box 687	it the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 □	Ectopic pregna			23d. Date of de Month	livery Day Year
rds, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cause	given in Part I.	23e. Did tobacc	_	o the cause of death?
al Record	The ate h page	Completed						24a. Was an autopsy performed 1 Yes 2 X	prior to death?	utopsy findings available completion of cause of 2 No
Vital	ysic s ce direc	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	ER/Outpatien	3 □ DOA	26. Place of Death Other: 4 \(\subseteq\) Nursing Hom	(Check only one)	6 Other (Sec	northe)
Division of	Attending r death. actor: After	Certification: 1	27. Manner of Death 1 🕅 Natural 2 Accident 3 Suicide 4 Homicide 2 Natural 5 Pending Investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifi	28b. Time of Injury	28c. li	njury at 2. Nork?	8d. Describe how in 8f. Location (Street City or Town, St.	ijury occurred and Number or R	
	To the Hospitel or within 24 hours afte To the Funerel Director Completely filled in the Funerel Director of the Funerel Direc	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the estigation, in m	e time, date and place, as y opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
)	To the within 2 To the complete	W	29b. Signature and title of certifier kerry?	(Windell	MO		ense number 4555		Date signed (Mont ptember	
) -	<i>V</i>			ell M.D. 192	41 Mon	,	Village Av	e. Montgo	mery Vil	20886 1age, Md.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Anna	61			

	223	ikc	. For		aryland / Depa					ibie.	
ζG		•	1 - State Registrar		Ce	rtificate of	Death		Reg. No.		32966
			Decedent's Name (First, Middle, I	ast)				2. Date of D		Vace	3. Time of Death
П	Physici	_	WOLFGANG	JA	KOBSBERG				ber 27,	Year 2004	4:07 PM
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death			y of Death	
н	Exami	· .	Suburban Hospita	1		Bethesda	а		Mo	ntgam	ery
	Funeral			Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Birthp	lace (State or Foreign
	Director		121-26-8801	1 X M 2□ F	71 Yrs.	Worths Days	Hours With.	APRIL	10, 1933	GERM	ÄŃY
	D .		Usual Residence of Decedent		I do a City Town and					1	0d. Inside City Limits
	how	_	10a. State 10b. County		10c. City, Town or Lo	ocation				'	1 X Yes 2 □ No
	e Ma	cto	MARYLAND MONTGO	MERY	POTOMAC						
	ith th	Director	10e. Street and Number			10f. Zip Code	a = 1		10g. Citizen of		itry?
	23e		11605 MILBERN DR				854		U.S.		
	r deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No Rican, etc.)	14. Ra	ice - Americ ack, White,	
98	or in	ΥF	1 Never Married 2 Married	If Yes, Give	.No	1 ☐ Yes 2 🔀 No	Specify:		Spec	ify: WHI	ਧਾਸ
Ö	72 hours after death with the Maryland natural", or Iteme 23a or 28a-f ehow Sical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:	160 Door	dent's Usual Occu	nation		16b. Kind of		
7	"nat	lete	15. Decedent's (Specify only highest	grade completed)	(Give	kind of work done DO NOT use retire	during most of wor	king			ORMATION
12	within ene. than	Ę	Elementary/Secondary (0-12)	College (1-4or 5+	5.41	NY PRESI			SYSTEM		
2	be filed within 72 hours after death with the Marylan ital Hygiene. I house them 23a or 28a-f ehow od other than "natural", or iteme 23a or 28a-f ehow event, it e Medical Examinar must be retified at		17. Father's Name (First, Middle, La		1		18. Mother's Nan	ne (First, Middi	e, Maiden Suma	ime)	
an	Mental Mental arkad o	o Be	ERNEST	JAKOBS	SBERG		GERDA			COHN	
Maryland 21215-0036	should and Men s marks sumatic	ို	19a. Informant's Name/Relationship			ng Address (Street	and Number or Ru	ral Route Num	ber, City or Tow	n, State, Zip	Code)
Ma	alth ar 27 Is		PAULINE D. JAKOB		11605	MILBERN	DRIVE, P	OTOMAC	MD 208	54	
ā,	Health tam 27		20a. Method of Disposition	DDBRO, NIII	20b. Place of Dispe			Date	20c. Location		wn, State
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marks any Injury ocether treumstic.		1 Burial 2 Cremation 3 1 Donation 5 Other (Spe		GARDEN OF	REMEMBR	ANCE 10/0	1/2004	CLARKS	BURG,	MD
≣	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Lie			-	SOLDBERG		AT CUADE	T C T	NC
B	permit. Departr Importe any Inju		1 Amanda	Ludonico	2 11	MZANSKI- 70 ROCKV	ILLE PIKE	ROCK	VILLE, M	208	52
			23a. Part1. Enter the disease, or shock, or heart failure. List or	omplications that cause							Approximate Interval Between
			Immediate Cause (Final							1	Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		s a consequence of):	IES				-	
	Examiner			50010 (0. 0.	2 3311334231133 31.7.						
	H.F.E.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of):						
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c c							
Ć,	exec n an	Exa	resulting in death) Last	Due to (or a	s a consequence of):						
760,	te be executed ysician and e burial-transit	ca		d							
68	leath certificate t attending physic I for use as the b	led							· 1		
Вох	h cer andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		⊒Ectopic pregnand	ev			ate of delive	
a	deat le att	500	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)	·			Month	Day Year
P.O.	The law requires that the death certifical tte has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	9 🗆 Unknown								
	res tha igned be del	by	Part II. Other significant condition	s contributing to death	but not resulting in the t	anderlying cause gr	ven in Part I.				he cause of death?
D	w require been si should b	ed						1	Yes 2 No	3 Proc	ably 4 □Unknown
သို့	aw re as be 2 sho	ple						24a. Wa	is an 24b		ppsy findings available mpletion of cause of
Ä	The law ate has page 2	Completed							formed?	death?	2□ No
of Vital Records,	icien: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only	one)		
f V	Physicien: r this certifica	10	examiner? 1 XYes 2 ☐ No	Hospital: 1 X Inpat	ient 2 ER/Outpatie	nt 3□ DOA Ot	her: 4 \sum Nursing H	lome 5 🗆 Re	sidence 6 🗆 O	ther (Specif	y)
0	ding Pt h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of In (Month, D	av Year) Injury	Wo	ork?	28d. Describ	how injury occi	LOU I	DED WITH
Ö	Attending in death, ector: After by the fune	atic	2€Accident investiga	11-11-	1 1204	2 M 1	Yes 2 No		MOBILE		
Division	or Attendation of the death of the office of	t#	3 Suicide 6 Could no determin	ad 280. Place of I	njury - At home, farm, state. (Specify)	treet, factory, office		28f. Location City or T	(Street and Nur. own, State)	nber or Rura	al Route Number, DLEY BWO, HD
	itel or A	Certification;			AD						
	Hospitel 24 hours a Funeral tely filled	edical	(Check only 2 Medical E	xaminer: On the basis	t of my knowledge, dea of examination and/or in						
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medi	one)	and manner	stated		se number		29d. Date sign		
	T vit	-	29b. Signature and title of certifier						_		
•	150		[[1 1 1 0 .] .]				O.C.M.E.		Septemb	CT 70	, 2004

State - Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUBIO, ND 11.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) OCT 04 2004

32. Registrar's Signature onthe

			Please 1	Гуре or Print in Black Iı	ndelible Ink. Ensure Al	II Copies Are	Legible.
			For Stata Registrar	,	partment of Health and Mertificate of Death	lental Hygien	2001 0001 =
			Decedent's Name (First, Middle, Last	")		2. Date of Death	3. Time of Death
	Physici /Medio		Helen Louise Jo	hnston		September	29, 2004 6:20 PM
	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death
			Laurel Regional Ho 5. Social Security Number 6. Se		Laurel v) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	g. Birtholace (State or Foreign
	Funeral Director			□M 2X)F 95 Yrs.	Months Days Hours Min.	(Month, Day, Year	9. Birthplace (State or Foreign Country) 1908 Nebraska
	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Examinat per notified at	ior	10a. State 10b. County Maryland Prince G	loc. City, Town or Adelphi	Location		10d. Inside City Limits 1 ☐ Yes 2X No
	r 28a-	Director	10e. Street and Number	eorge's Aderphi	10f. Zip Code	10g. C	itizen of What Country?
	th with		3210 Powder Mill R	load	20783	USA	Α
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fu	1 Wever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 【XNo Specify:		Specify: White
0	2 hour	ted t	15. Decedent's Edu	ucation 16a Dec	edent's Usual Occupation	. 16b.	Kind of Business/Industry
Maryland 21215-0036	within ane. than	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	re kind of work done during most of work. DO NOT use retired) ctor of Rural Healt		leral Government
and 2		Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	
Z	should be and Mental I s marked o	မှ	George Abel Johnst 19a. Informant's Name/Relationship (T)		iling Address (Street and Number or Rur		or Town, State, Zip Code)
			Dennis James/cousi		8 Cedar Lane Belts		
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tru		20a. Method of Disposition 1 ☐ Burial ②XXCremation 3 ☐ I	Removal from State	ematory or other place) UCTO	ober 5,	Location - City or Town, State
Itin			 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Ligens 		del Crematory 200 22. Name and Address of Facility		enton, Maryland
Ba	permit. Departr Importe any inju		Beverly & He	MO1251B	oing Home Cremation everly L. Heckrotte	n Service e, P.A. Cla	P.O. Box 784 arksville, MD 21029
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the death. Do not e one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular A Due to (or as a consequence of):	ccident		2 days
į,	Examiner	L	Sequentially list conditions,	b			
	cuted nd ransit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	execut n and al-trar	Exan	that initiated events resulting in death) Last	c			
68760,	ficate be exec physician an is the burial-tr		(d			
89	ing ph	Med	IF FEMALE:				
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 VV0 9 Unknown		B Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
٩	res that the designed by the	y Ph		ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	quires n sign uld be	ed by	Hypertension; Coro	nary Artery Diseas	e ;	1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	te law requir has been si ge 2 should	Completed	Congestive Heart F	Failure		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital		e Co	25. Was case referred to medical		26 Place of Deat	1 ☐ Yes 2 📉N h (Check only one)	lo 1 Yes 2 No
Ž		To B	examiner?	Hospital: 1 XInpatient 2 ☐ ER/Outpati	Other	ome 5 Residence	6 ☐Other (Specify)
on of	ng lety eur	tion: 1	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how inj	ury occurred
Division	o the Hospitel or Attending thin 24 hours after death. I the Funeral Director: After ompletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	o the Hospitel or ithin 24 hours after o the Funeral Dir ompletely filled in	edical C	29a. Certifier 1 X Certifying Phyone 2 Medical Examone)	ysician: To the best of my knowledge, de niner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause(red at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	o the	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R.G. Bhojraj M.D. 704 Gorman Ave. #T-1 Laurel, Maryland 20707

31. Date filed (Month Pay, 1993) 2004 32 Segistrar's Signature

D23181

October 3, 2004

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tam 27 is marked other than "naturer, or itams 23a or 28a-f show any injury or other traumatic evant, Ital Medical Exercited in a stice rectified at once.

To Be Completed by Funeral Director

	Phy /M Exa	sicia edica mine
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

	se Type or Pri	nt in Black In aryland / Depa			•		
For State Registrar	Julio Oi IV		rtificate of			g. Ne.)	000
1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	7 - 1 - 1 - 1	3. Time of Death
ROBERT LEE	JONES				OCTOBER		The state of the s
a. Facility Name (If not institution,				or Location of Death		4c. County of Dea	
SINAL HOSPITAL		عة (In yrs. last birthday)	BALTIN If Under 1 Year		8. Date of Birth	BALTIMOR	E CITY thplace (State or Foreign
217-42-9995 Usual Residence of Decedent	1 ⊠ M 2□F	59 Yrs.	Months Days	Hours Min.	(Month, Day,	Year) C	ARYLAND
0a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit:
MARYLAND WASH	INGTON		HAGE	RSTOWN			1∭Yes 2□N
0e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
1054 GEORGIA AV		É		1740		U.S.A	
 Marital Status Never Married 2	12. Was Deceden Armed Forces ed 1 ☐ Yes 2 🛭		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Am Bleck, Wh	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 🖸 No	Specify:		Specify:	WHITE
15. Decedent		16a. Dece	dent's Usual Occu	pation	1	6b. Kind of Busines:	
(Specify only highes Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retire	during most of work ad)	ing		
10			TENANCE I	T		COLL	ÆGE
7. Father's Name (First, Middle, I					e (First, Middle, M	20	
JAMES WILLIAM				<u> </u>		A BUSSARD	
9a. Informant's Name/Relationsh			,	t and Number or Run			
BETTY J. JONES/S	SPOUSE	20b, Place of Dispo	osition (Name of	AVENUE, F		Oc. Location - City o	
1 ☑ Burial 2 ☐ Cremation		•	matory or other pla				
. 4 □ Donation 5 □ Other (Sp. 1. Signature of Fun 1 Service I		SAMPLES	MANOR CE 2. Name and Addr				MARYLAND
	5	zmmerman B	AST FUNE	RAL HOME		l National o, Maryla	
shock, or hear failure. List immediate Cause (Final disease or condition esulting in death) Sequentially list conditions, any, leading to immediate ause. Enter Underlying hause (Disease or injury hat initiated events esulting in death) Last	a. MYC Due to (or a b. COR Due to (or a		NFARCTI	DN SEASE_			Onset and Death TWO WEEKS TEN YEARS
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	y		23d. Date of de Month	alivery Day Year
art II. Other significant condition	ns contributing to death	but not resulting in the u	underlying cause gi	ven in Part I.			to the cause of death?
INTERSTITIAL	PULMONAR	FIBROSIS			1 Tryes	2 □ No 3 □ P	robably 4 Unknow
PERIPHERAL	VASCULAR	DISEASE			24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings availab completion of cause of s 2 \(\sum \text{No} \)
25. Was case referred to medical examiner?	Hospital:		0.	han	h (Check only one		
1 ☐ Yes 2 ☑ ✓ o 7. Manner of Death	Hospital: 1 Inpa		III 3L DOX		ome 5 Resider	nce 6 Other (Spa	ecify)
1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	not be as a Blace of le		M 1	rk?]Yes 2 □No			Rural Route Number,
4 ☐ Homicide determ	ined 288. Place of It	njury - At home, farm, st tc. (Specify)			City or Town,	State)	
(Check only 2 Medical one)	g Physicien: To the bes Exeminer: On the basis and manner:	of examination and/or in	ivestigation, in my	ime, date and place, opinion, death occurs se number	red at the time, dat	use(s) and manner a te and place, and du d. Date signed (Mon	e to the cause(s)
	Cho MiD		D4			TOBER 4,	
30. Name and address of person PETER W. CHO, I	M.D. 2435	W. BELVEDER	. Print) E AVE, SU	ITE 35 BA	HIMORE, I	10 21215	
31. Date filed (Month Day Year)	32. Pigis	trar's Signature	1.10				-

DHMH 17 Rev 1/2001

State Registrar

			For State Registrar	State of Maryland /	•	irtment of H		and Menta		ne . No. 2 (1) (1)	3201.0
			Decedent's Name (First, Middle, Last)						of Death		3. Time of Death
	Physicia /Medic		Vanessa Nichole	Jenkins				Och	sbe-	Day Year S 2004	8:56 PM
Ž	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location o			4c. County of Dea	th
			Washington Count			Hagerst	Own				on County
	Funeral		5. Social Security Number 6. Sex	M 2X F 7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under	Min. (Mor	of Birth	9. Bir Co	thplace (State or Foreign ountry)
	Director		214-13-6918 Usual Residence of Decedent	23				Dete	ober z	28,1980 Ma	aryland
	nylanc how		10a. State 10b. County	10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Ba-f s	Director	Maryland Washingt	on s	mith	sburg					1 Tes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Code			10g	. Citizen of What Co	ountry?
	eath	erai	20950A Twin Spri	ngs Drive 2. Was Decedent Ever in U.S.	13. V	Vas Decedent of H		gin? (Specify Yes	or No-	U.S.A.	erican Indian.
36	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or itams 23a or 28a-f show any injury or other treumatic event. Its Medical Examinar must be notified at ance.	by Funerai	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba □ Yes 2∑ No		i, Puèrto Rican, e	tc.)	Black, White	•
Ö	72 hou	ted	15. Decedent's Edu	cation 16	ia. Deced	lent's Usual Occup	ation	t of working	16	b. Kind of Business	/Industry
215	ithin 7 19. Med "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done		or working			
2	led w lygier her th	ပ္	12 17. Father's Name (First, Middle, Last)		He	alth Wor		r's Name (First,		<u>lealth Der</u>	partment
anc	otal F) Be	Mark L. Jenkins					ina M. J		,	
Ž	should nd Me mark mark	유	19a. Informant's Name/Relationship (Ty)	pe, Print) 19	9b. Mailin	g Address (Street				ity or Town, State, .	Zip Code)
Š	aith a aith a 27 is		Mark L. Johnson	(Father)	8482	Lyons 1	Road V	avnesbo	ro. P	enrsylvar	ia 17268
Zre,	es 1 a of He fitem r othe		20a. Method of Disposition 1 Burial 2 X Cremation 3 R	20b. Place cemei	of Dispos tery, cren	sition (Name of natory or other place	ce)	Date	20	c. Location - City or	Town, State
<u>Ĕ</u>	Page ment ent: It ury o	. 19	`4 ☐ Donation 5 ☐ Other (Specify)	Smith							Maryland
Baltimore, Maryland 21215-0036	Depart Import any in		21. Signature of Funeral Service License	7	22	. Name and Addre	ss of Facilit	y Dougla	s A.	Fiery Fun	eral Home
	707 e 0		23a. Part1. Enter the disease, or compli	cations that payed the death. D.	1	331 Easte	ern Bl	Lvd. N.	Hager	stown Mar	vland 21742
			shock, or head failure. List only or Immediate Cause (Final	e cause on each line.			_		atory arrest	,	Approximate Interval Between Onset and Death
	Enysician /Medical	1	disease or condition resulting in death)	ACUTE ISC Due to (or as a consequence		MIC S	STRO	KE			FOUR DAYS
Į.	Examiner					AL CA	ROT	ID TH	RON	130515	FUUR DAYS
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence							
	nd nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	cate be executed oblysician and the burial-transit	i EX	resulting in deathy Last	Due to (or as a consequence	e oi):						
387	physicate to physicate the true to the true true true true true true true tru	dicai									-
Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy						23d. Date of de	livery
	death e atte	icia	in the past 12 months? 1 □ Yes 2 🗷 No	1 Live birth 2 Fetal dea]Ectopic pregnancy] Other <i>(specify)</i>	/			Month	Day Year
0.0	at the by th	hys	9 🗆 Unknown	9□ Unknown							
	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significent conditions cor	tributing to death but not resulting			en in Part I.	236		_	o the cause of death?
oro	requi	eted	1710	(/ LIVE ((I)) CI				_	-		
Vital Records,	82 S	mpi						24a	 Was an autopsy performer 	prior to	utopsy findings available completion of cause of
a	n: Th ficate or, pay	e Co	25. Was case referred to medical				00 81		Yes 2 🗷		2 □ No
Ξ	Physicien: this certific ral director,	To Be	examiner?	lospital:	Outpatien	t 3 DOA Oth	0.00	of Death (Check		e 6 Other (Spe	cifv)
1 0	ding Physiclen: The land. After this certificate ha funeral director, page.		27. Manner of Death		. Time of		y at			injury occurred	,,
sior	Attending r death. sctor: After by the fune	atic	1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 🗆	No			
Division of	- 0 - C	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Loci City	ation (Stree or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospitel o within 24 hours aff To the Funeral Di completely filled in	edicai C	29a. Certifier 1 Certifying Physic (Check only one)	sician: To the best of my knowled ner: On the basis of examination a and manner stated.	lge, death and/or inv	n occurred at the tir vestigation, in my o	me, date an pinion, dea	d place, and due th occurred at the	to the caus time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifies	and maillet outside.		29c. Licens	e number		29d.	. Date signed (Mont	th, Day, Year)
	- 5 - 0		> Saum Mi			D	508	07		TOBER O	
ı	H'S		30. Name and address of person who co	mpleted cause of death (Item 23a) /// Medical 32. Significants Signature	a) (Type,	Print)	Rd	Itan.	md	2/74	7
Ĭ	Sta Regist	ate rar	31. Date filed (Monto PT YO') 8 20	04 32. Fegistrar's Signature	A.	will a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	/			
								_ .			

			For State Registrar	State of M	aryland /		artment of latificate of		and Mental Hy	giene	AL 32950
			1. Decedent's Name (First, Middle, Last,						2. Date of De Month	eath Day.	Year Year
	Physicia /Medic		Alice Emma Keller							30	2004 0722 M
	Examin		4a. Facility Name (If not institution, give	· ·			4b. City, Town,		of Death	4c. County	
			Carroll Hospital 5. Social Security Number 6. Secu		e (In yrs. last	hirthday)	Westmin		24 Hrs. 8. Date of Bi	Carrol	
	Funeral Director			M 2∑F	77	Yrs.	Months Days		Min. (Month, D.) May 12	av. Year)	9. Birthplace (State or Foreign Country) Maine
	land		10a. State 10b. County		10c. City, T	own or Lo	cation		•		10d. Inside City Limits
	Mary -1 sh	tor	MD Carroll		Finks	burg					1 ☐ Yes 2X No
	r 28e	Funerai Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?
	h wit	aiD	2404 Shawnee Driv	e			21048			United S	States
	ems r m	ner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of f Yes, specify Cul	Hispanic Ori ban, Mexicar	gin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Rad Bla	ce - American Indian, ck, White, etc.
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show fra M. Joal Exaciter must be notified at	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 If Yes, Give			1 □Yes 25☑No				^{ry:} White
Š	hours tural',	ed by	3 ₩ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	1	6a Decer	dent's Usual Occu	pation			Business/Industry
7	n 72	ojete	(Specify only highest grad	e completed)		(Give	kind of work done DO NOT use retire	during mos	t of working		gton, DC
21215-0036	I within liene.	Completed	Elementary/Secondary (0-12)	College (1-4or		elep	hone Ope	rator		-	Department
ğ	be filed withintal Hygiene. d other than	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Middle	, Maiden Sumar	ne)
/lar	should be ind Mental I marked o	ToE	Charles Earl Cook	son				Clara	a Belle Tay	lor	
Maryland	01 00 00 00		19a. Informant's Name/Relationship (T)	rpe, Print)	1	19b. Mailir	ng Address (Stree	at and Numbe	er or Rural Route Numb	er, City or Town	, State, Zip Code)
	ss 1 and 2 of Health Itam 27			Daughter			Shawnee		Finksburg,		
ore	ges 1 t of H If Itan or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ F	Removal from State	·		sition (Name of natory or other pla		Oct. 3,	20c. Location	- City or Town, State
틆	Pag tment tant:		`4 □Donation 5 □ Other (Specify)		Sout		roll Cr			Winfiel	
Baltimore,	permit. Pages 1 Department of F Important: If Its any Injury or ot	e p	21. Signature of Fundad Service Licens	٠		B1	urrier-Q 212 W. O	ueen I 1d Lit	uneral Hom berty Road	e & Crem Winfield	natory, P.A. 1, MD 21784
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that cause ne cause on each I	d the death. I ine.						Approximate Interval Between Onset and Death
	- Pnysician	8 11	Immediate Cause (Final disease or condition	ACC	TE	C88	53 LA	+4	HEMORE	1446 8	7
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ice of):)				
		<u>_</u>	Sequentially list conditions, if any, leading to inniediate	b. 77 9 d	\$ 12.75 a consequen	ca off:	7070				
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	A-7	ZIA	7_	TAR	RI	LATTON)	
	be executed sician and burial-transit	Xar	that initiated events resulting in death) Last	c. Due to (or as	a consequen	nce of):					
200	ate be e ysiciar he buri	icai		d							
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit									p	
ŏ	leath certifical attending phy ifor use as th	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome 1 □ Live birth			Ectopic pregnan	cv			ate of delivery
Э.В	deat he att	sicis	in the past 12 months? 1 Yes 2 XNo	4□Pregnant a 9□Unknown			Other (specify)			M	onth Day Year
P.0	at the de	Phy	9 Unknown			1001 - 400	Section value of the	one in Dead	220 Did	tabaasa usa saa	tribute to the cause of death?
Ś	res that signed b	by	Part II. Other significant conditions co	ntributing to death i	but not resultir	ng in the u	nderlying cause g	iven in Part i		Yes 2 No	3 ☐ Probably 4 ZUnknown
Records,	w require been si should l	Completed	11/30/2							T	/
Sec	e law has b	nple							24a. Wa:	s an 24b. opsy ormed?	Were autopsy findings available prior to completion of cause of death?
a F									1 ☐ Yes	3 □ No	1 Yes 2 No
Vital		Be	25. Was case referred to medical examiner?	Hospital:	· · · · · · · ·				of Death (Check only		
of	Phys ral di	1; To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati	urv 28	VOutpatier Bb. Time o			ursing Home 5 Res	how injury occur	
on	ding P	tior	1/X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury		ork? ⊒Yes 2. 🗆	No		
Division	or Attanding after death. Diractor: After in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	njury - At home etc. <i>(Specify)</i>	e, farm, str	reet, factory, office	9		(Street and Numi	ber or Rural Route Number,
	To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: Atter completely filled in by the funer								nd place, and due to the		anner as stated. and due to the cause(s)
	ths F tha F nplete	Medical	one)	and manner s	tated.	_ # 41					
	With To	2	29b. Signature and title of certifier					nse number	2	San Date Slove	ed (Month Day, Year)
,	to a		1000				2	252	41	1/3	V 107
	in a		30. Name and address of person who d	ompleted cause of 32. Region 2004	death (Item 23	sa) (Type,	Print) ADO	المالياء الم	MIALNE. 26	15/26 AZNO1	LE HOSP CAR
_	C+	ate	31. Date filed (Month, Day, Year)	32. Regid	frar's Signatur	0		0 1		W SST	MINSTED. MO.
1	Regist		OCT 0 5	2004	wer.	K.	Sparle				, , ,

State of Maryland / Department of Health and Mental Hygiene

				Clate of Ivial	•	Certifica	te of L	Death		Reg. No 2 () () ()	32951
	D: ::		1. Decedent's Name (First, Middle, Last)						2. Date of De- Month	eth Day Year	3. Time of Death
W.	Physicia /Medica		MARK WILLIAM KE	NNEDY						BER 26, 2004	
)	Examine		4e Fecility Neme (If not institution, give s						Location of Deeth		
			WESTMINSTER NURSIN	G/REHABIL	ITATIO	1 CENTE	R	WESTMIN		CARROL	
	Funeral		5. Social Security Number 6. Sex	7. Age (M 2□ F	In yrs. last birti	rs. If Und	er 1 Year Deys	If Under 24 Hrs Hours Min.	8. Date of Birl	9. Birth ER 16,1943	nplace (State or Foreign untry)
Ы	Director	-	108-34-7064 Usual Residence of Decedent	(60 Y	13.			140 4 111.	LEC 10/1513	NEW YORK
	B &	}	10a. State 10b. County	1	0c. City, Town	or Location					10d. Inside City Limits
	er er	5	MARYLAND CARROLI	-	MESTIM	INSTER					1 ☐ Yes 2 🔀 No
	28 119	<u> </u>	10e. Street end Number		1110111		ip Code			10g. Citizen of What Co	
	A S		514B OLD WESTMINS	TER PIKE			2115	57		UNITED STA	TES
	death	era era	11. Marital Status	2. Was Decedent Ev	er in U,S.	13. Was Dec	edent of Hi	ispanic Origin? (S	Specify Yes or No to Rican, etc.)	14. Race - Ame Black, White	
0	T to	בֿ ב	1 Never Married 2 ☐ Married	Armed Forces? 1XX es 2 □ No If Yes, Give				Specify:	to riloan, oto.)		
22	Sunce in the sunce	ğ	3 ☐ Widowed 4 ☐ Divorced	Yes, Give Year or Dates: V	TETMAM					4411	ITE
2	filed within 72 hours eiter death with the Meryland Hygiene. ther than "natural", or terms 23a or 28e-f show ont, the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's Us (Give kind of w	uel Occupa vork done d	ation during most of wo f)	rking	16b. Kind of Business/	Industry
2		E E	Elementary/Secondary (0-12)	College (1-4or 5+)		TECHN				STATIONAR	Y STORE
7	her t	ပ	17. Fether's Neme (First, Middle, Lest)	1		IIICIII.	10111		me (First, Middle,	Maiden Surname)	
and	d of	e e	(NOT KNOWN)					(NOT KN		,	
2	should be to and Mentel I a marked of umatic eve	٩	19a, Informant's Name/Relationship (Type	ne Print)	19b	Mailing Addre	ss (Street i	and Number or R	ural Route Numb	er, City or Town, State, 2	Zip Code)
Σ	trau		MICHAEL KOELBL/FRI	•				D COURT,			21102
စ်	Health Health tam 27	1	20a. Method of Disposition		20b. Place of	Disposition (N	ame of		Date	20c. Location - City or	Town, State
ê .	Peges nent of l int: if its iry or o	-	XX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State				ETERANS	10/01/20 CEMETERY	OWINGS MII	LS, MD
Baltimore,	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryler Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	21. Signature of Funeral Service License	е		22. Name	and Addres	ss of Facility			
ä	9 5 E 8		Alusti R &	Durk	orco	MYERS	S-DUF	RBORAW S STREE	FUNERAL T. WEST	HOME, P.	A. MD 21157
		1	23a. Part1. Enter the disease, or compliant shock or heart failure. List only on			ot enter the me	ode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
and I	hysician	1	SHOCK OF HEART FAILURE. EIST OFFING OF					*			Onset and Death
A.	/Medical		Immediate Cause (Final disease or condition	Meta:	static	Can	cer	Hen	9		3 years
	Lastiner		resulting in death)			onsequence o		(0	 	
	ed sit	틸	_ b								
	The lew requires that the death certificete be executed ete has been signed by the ettending physician and page 2 should be deteched for use es the bunel-transit	edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Di	ue to (or as e o	onsequence o	f):				
68760,	siciar siciar buni	g	Ceuse (Disease or injury that initieted events		e to (or as a c	onsequence of	7).				
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Patricia Kalis-Larkin 28, 2004 6:00 Sep. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F 83 215-12-0454 11, 1921 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b. County or 28a-f show the Medical Examiner must be notified at Arnold MD 1 Yes 2 No Anne Arundel Completed by Funeral Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21012 544 Broadwater Road 238 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? TYes 2 □ No WWII 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing 3 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked otl Aileen Mooney Patrick McCusker 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 544 Broadwater Road, Arnold, MD 21012 John R. Larkin/Husband item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition rtment of H rtant: If ite njury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oct. 1, Crownsville, MD MD Veterans Cemetery 2004 permit.
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any inju 21 signature of Fineral Service L 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21146 495 Gov. Ritchie Hwy, Severna Park, MD art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. mmedia a Cause (Final disease or condition rank ling in death) Pnysician /Medical Due to (or all a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed attending physician and for use as the burial-transit tarlater and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. be 1 Tyes 2 No 3 Probably 4 Unknown Carenon Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No. Division of Vital Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifice 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 1 🗌 Yes 27. Mann f Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3306 6 of person who impleted cause of death (Item 23a) (Type, Print) Ste 211 Annapoles, 715 888 Marn 32 Registrar's Signature Day, Year) State Registrar

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Jewand J. Cale mas 0041211 10/1/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	the phone	Med		and manner state		2	29c. License	number		29d. Date s	signed (Month	n. Dav. Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	F 8			1 1. 0								- ,
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State Registrar Dr. Fernando Acle (arral) St. Salisburg Mad 2180) 31. Date filed (Month, Day, Year) OCT 0 4 2004 Server & World							A - /	Α	1 1			

9/29/84 1045Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month OCtober Day **Physician** WALTER FRANCIS LAWTON 3, 2004 4c. County of Death :15 4M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CumberLand HOSPITAL ALLEGA SACRED HEART If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Director July 22, 1930 031-22-7896 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show Ever treer rost be notified at Lisbon Falls Maine (Unknown) 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 04252 USA 76 Summer Street Itams 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene int: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Elizabeth Pelletier Walter Henry Lawton ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawton (Wife) 76 Summer Street, Lisbon Falls, Maine 04252 Alice other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 X Removal from State permit. Page:
Department o
Important: If i
any injury or October 8, ò Brunswick, Maine Riverside Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Paul T. Ichtamofor Name and Address of Facility Funeral Home, Inc. 21. Si mature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 48 S. Church Street, Waynesboro, PA 17268 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) obstructive Pnysician Chronic 10 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, for any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examiner The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 an/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Completed by Physici 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? moline Resovator Obstructive 1 Pres 2 No 3 Probably 4 Unknown failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hyportension, Cardiac arrhythmias 2 No 1 Yes 2 - No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification; To s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Amarefemacin, M-1).

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month Year)

HUSAM SEMAAN, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Maren B. Sparks

Sourced Heart

ORIGINAL

Hospital

056207

cumbuland MD

10-3-04

		•	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			jiene eg. No. () () ()	32956
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	th Day Yea	3. Time of Death A
	Physicia /Medic		Leroy Charles LO	OCKARD				October		. / / / / / / / / / / / / / / / / / / /
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	r Location of Death		4c. County of De	ath
			Washington Count	ty Hospita	1	Hagers	town		Washing	rton
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	р.		Usual Residence of Decedent		1					
	how thow	b.	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma talifie	cto	Maryland Washing	gton	Hag	erstown				1 X Yes 2 □ No
	th th or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	23a	le l	128 E. First Stre	eet			740		U.S.A	
	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.
ထ္ထ	or It		1 Never Married 2 Married	1 X Yes 2 ☐ ! If Yes, Give	No	1 ☐ Yes 2 🗓 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland one. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed by	3 XWidowed 4 □ Divorced	Year or Dates:	W.W. II					
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2	lled v lygie ther t		unknown 17. Father's Name (First, Middle, Last,	<u>unknown</u>	Jan	nitor	18 Mother's Nam	e (First Middle I	system Maiden Sumame)	
and	be f	Be		,						
Ĕ	d Mel nark	7	Elmer Lockard 19a. Informant's Name/Relationship (Time Oriet)	10h Maili	n= Addross /Stroot	Kather		nknown r, City or Town, State	Zin Codol
Maryland	12 sl h an 7 is r traur									
ص ص	1 and Healt		Linda Neff - Daug	gnter	20b. Place of Dispo	E. First			wn, Md. 21 20c. Location - City of	
altimore,	ges If of h		1 🔀 Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other plac	ce)			
<u>ij</u> .	tant tant		`4 ☐ Donation 5 ☐ Other (Specif			wn Mem. P			Hagerstown	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural, or liems 23a or 28a-f show any injury or other traumatic evant, its Medical Examinar must be notified at once,		21. Signature of Funeral Service Licer	Rank		2. Name and Addre 415 E. Wi	. $1 {\sf son} {\sf B1v}$		uneral Hor rstown, Mo	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not en				est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final	7/ 447	The action	File	illotin + Foi Lise			Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence of):	1000	0-0-14			1.00000
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		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	ಷ ರವಾಶಕವಾಗರ ರಕ್ಕೆ.		^ .			93
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Little	Shakey (Attition	Llise	ese		years
Ć.	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequ ce of):					
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Вох	that the death certifi ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		JEctopic pregnancy			23d. Date of d	elivery
m	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		Other (specify)	, 		Month	Day Year
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J.	The law requires that te has been signed b age 2 should be deta	by P	Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	bacco use contribute	to the cause of death?
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Vital		ပိ	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes a	/	as 2□ No
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Division	or Attending after death. Diractor: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	200. Flace of III]	ury - At home, farm, st	reet, factory, office		28f. Location (St	treet and Number or	Rural Route Number,
Ö	after Dirac	Certification:	4 Homicide	building, et	c. (Specify)			City or Town	n, State)	
	To the Hospital or Attend within 24 hours after death to tha Funeral Diractor; completely filled in by the	alc	29a. Certifier †Scertifying Pl	nysician: To the best	of my knowledge, deat	h occurred at the tir	me, date and place,	and due to the ca	ause(s) and manner	as stated.
	e Ho 124 I a Ful letely	edical	(Check only 2 Medical Example)	miner: On the basis o and manner st	f examination and/or in	vestigation, in my o	pinion, death occur	red at the time, d	ate and place, and d	ue to the cause(s)
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BOX 687 Beath certificate attending phys		Physician/Med	IF FEMALE:	23	c. If yes, o	utcome of	f pregnar	ncv						23d. D	ate of de	iverv	
		ian	23b. Was decedent pregnant in the past 12 months?		1□Live	birth 2	Fetal	death 3	Ectopic pr Other <i>(sp</i>		'			1	lonth	Day Year	
. 0 00	1	ysi	1 □ Yes 2 ☒ No 9 □ Unknown		9□ Unk				,								
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age le 🕱		E											performed Yes 2√2	1?	death?		
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On Of ding Phy h. After this funeral d		ü	27. Manner of Death 1 ⊠Natural 5 ☐ Pendi	na	28a. Dat (Mo	e of Injury onth, Day	Year)	28b. Time o Injury		28c. Injur Wor	k?	28d.	Describe how	injury occu	irred		
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	600	Medical	(Check only 2 Medice	Examin	er: On the	basis of a	examinat	tion and/or in	vestigation	i, in my	pinion, death oc	curred at	the time, date	and place	, and due	e to the cause(s)	
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			30. Name and address of person	who cor	npleted ca	use of de	ath (Item	23a) (Type,	Print)								
			Thomas G. Jo						urth	St.,	0aklan	d, Me	d. 2155	0			
	Sta		31. Date filed (Month Day Year	1 6 21) 04 32.	. Registra		ture	Joseph	10							
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GEORGE W. LEE	E JR.	State of Maryland	Department of He	ealth and Ment	tal Hygiene	

ORC	SE W. L	EE	JR. 1 - State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H			ene g. No. A A	1 22050
			Decedent's Name (First, Middle, La	ast)	, , , , ,			2. Date of Death Month		3. Time of Death
	Physici /Medi		George W. Lee,	Jr				SEPT.	26, 20	
	Examir		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or	Location of Death		4c. County o	
			3410 NOTTINGHAM			WESTM1			CARR	
	Funeral Director		213-70-7027	Sex 7.A 1 ☑ M 2 □ F	ge (In yrs. last birthday) 48 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 05	^{Year)} 1955	Birthplace (State or Foreign Country) MD
	pue *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	ier death with the Marylan Items 23a or 28a-f ahow Instruust Lean villied all	ō		rroll	West	tminster				1 ☐ Yes 2 🔀 No
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020	be filed within 72 hours after death with the Maryland hal Hygiene. dother than "natural", or Items 23a or 28a-f ahow event, the Mcdical Examinat must be invitified at	by	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	[No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)	Specify:	White, etc. White
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<u>₹</u>		은	George W. Lee,		401 44 111	- 111 (0)				2-4-7- O-4-1
, Maryland 21215-0036	uth ar 27 is r trau		19a. Informant's Name/Relationship Edith Lee/wife	(Type, Print)	341	ng Address (Street and Notting)	ham Road	Westmin	ster, M	ID 21157
Baltimore,	of of or		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec			osition (Name of matory or other place s Luthera	-/ 1	1/2004		ent, MD
Bait	permit. Pag Department Important: any injury o	ļ	21. Signature of Funcial Service Co.	and the second		2. Name and Addre ritts Fun 12 Washin				
т			23a. Part1 Enter the disease, or con shock, or heart failure. List onl	mplications that cause	ed the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	01		chelia				Onset and Death
	/Medical		resulting in death)	a Due to (or a	s a consequence of):	OTION				
	Examiner		Conventially list conditions	h						
	D ==	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	s a consequence of):					
	ocuted nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	tcate be executed physician and s the burial-transit	dlcal Ex	resulting in dealin, cast	d.	s a consequence of):					
9	tificat ig ph) as th	a a								
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date Mon	e of delivery th Day Year
۵.	that the di ed by the detached	Ph	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contri	bute to the cause of death?
ds,	uires tha signed I d be det	d by		· ·	-	, , ,		1 □ Ye	s 2 X No :	3 ☐ Probably 4 ☐Unknown
Records,	w requir been si should	Completed						24a. Was an	24b W	/ere autopsy findings available
ě	e lav has	Id m						autopsy	/ pr	rior to completion of cause of eath?
a										XYes 2□No
Vital	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:		et all post Oth	00	th (Check only one	2.5	(Cassife) ATT COUNT
o		1.10	1 XYes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of In		nt 3 DOA	4 🗀 Nursing n	28d. Describe ho		r <i>(Specify)</i> AT SCENE
no	Attanding F r death. actor: After by the funer	Certification;	1 Matural 5 ☐ Pending	(Month, E	<i>Bay Year)</i> Injury	Wor	k? Yes 2 □ No		1	
Division	Attandi death. ctor: A	lica	3 Suicide 6 Could not	be gen Blace of I	njury - At home, farm, si			28f. Location (Str	eet and Numbe	r or Rural Route Number,
<u>≤</u>	lor after Dira	erti	4 Homicide determine		etc. (Specify)	,,		City or Town,	, State)	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying I	Physician: To the bes aminer: On the basis and manner	st of my knowledge, dea of examination and/or instated.	th occurred at the tir ovestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and man ite and place, a	nner as stated. nd due to the cause(s)
	To the vithin. To the comple	Me	29b. Signature and title of certifie	/	14-	29c. Licens		29	-	(Month, Day, Year)
•	MIL			NVIL	1		C.M.E.		SEPT.	27, 2004
	V00 5		TARK M. T	itus m.D	death (Item 23a) (Type 111 Pen	n Street,	Baltimo	re, Maryl	land 212	201
4	St	ate	31. Date filed (Month, Day, Year)	32. Regi	gar's Signature					
	Regist	rar	SEP 2	8 2004	low &	Sperte				
DE	MH 17 Rev 1/	2001			6.					

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar/MFND#17per1		Maryland / Dep	ertificate of		Mental Hy	/giene	32050
	Physici	an	Decedent's Name (First, Middle,					2. Date of Do	eath Day Year	3. Time of Death
	/Medic	al	Alexander	Mack				Septe	mber 29, 20	
4	Examir	er	4a. Facility Name (If not institution, g Washington Adve				or Location of De	ath	4c. County of Dea	
	Funeral				Age (In yrs. last birthda)	Takoma		rs. 8 Date of Bi	Montgome	
	Director		247-42-1967 Usual Residence of Decedent	1 ∑ M 2□F	75 Yrs.	Months Day			, 1929 Sou	thplace (State or Foreign ountry) th Carolina
	show		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	the Maryla 28e-f shov	ctor	D.C. N/A		Washing	ton				1X□Yes 2□No
	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	s 23a	rai	1414 Parkwood P		. 5	20010			United Sta	
	72 hours after death with the Maryland natural', or items 23a or 28e-f show ilical Evar. it wit must be multiled at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces	3? 1955 –	Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14. Race - Am Black, Whi	
036	ours aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	1957	1 ☐ Yes 2Ñ No	Specify:		Specify: B1	ack
21215-0036	72 hours natural', dical En	Completed	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occu	upation	endrina	16b. Kind of Business	/Industry
121	vithin ne. han *	mpl	Elementary/Secondary (0-12)	College (1-4o	(5+)	e kind of work don DO NOT use retir	ed)	ionaling .		
2	filed within Hygiene. other than ent, the M		8 17. Father's Name (First, Middle, La	(et) 11 m le	Mai	lhandler	19 Mother's M	ann /Finn Adidde	Post Offic	e
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Montal Hygiene. Importent: if item 27 is marked other than any injury or other traumatic event, IteM ODICE.	ТоВе	Bennie Mack	and the second			Viola	ame (rirst, Middle	. Maidan Sumame)	
ary	shoul nd Me mart	F	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stree		Rural Route Numb	per, City or Town, State,	Zip Code)
	and 2 alth a 27 is		Marcella Mack	(wife)					ington, D.C	
Baltimore,	St He Tite		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other pl	ace)	Date	20c. Location - City or	
Ĕ	Pag ment ent: i		1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spe	cify)	0	Cemeter		5/04	Triangle,	VA
3alt	Depart Import any inj		21. Signature of Funeral Service Lic	censee	2	2. Name and Addi	ess of Facility N	cGuire F	uneral Serv	
_	205 4 9		23a. Part1. Enter the disease, or co	oupson						D.C. 20012
8760,	Physician /Medical Examiner hysician and pural-Itausit tube prival-Itausit physician and prival-Itausit physician p	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of): Style C s a consequence of): Style C s a consequence of): The consequence of conseque	7		1.Jonsé		Interval Between Onset and Death
O. Box 6	death certific e attending p d for use as	Physician/Medical	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 ☐ Live birth	e of pregnancy 2 Fetal death 3	□Ectopic pregnand □ Other (specify)	-		23d. Date of del Month	ivery Day Year
Records, P.	The law requires that the ste has been signed by thi page 2 should be detache	þ	Part II. Other significant conditions	s contributing to death	but not resulting in the t	indertying cause g	ven in Part I.	23e. Did t	obacco use contribute to	othe cause of death?
Ö	w require s been sig	Completed						24a. Was	an 24h Were au	topsy findings available
Re	The lav	Eo							prior to death?	completion of cause of
Vital	ician: Th	BeC	25. Was case eferred to medical examined?				26. Place of De	1 ☐ Yes eath (Check only o	2 ☑ No 1 ☐ Yes	2□ No
of V	Physician: this certific ral director,	To	1 Yes 2 No	Hospital: 1 Inpat		nt 3 DOA	her: 4 🗆 Nursing	Home 5 ☐ Resid	dence 6 □Other (Spe	cify)
u C	ding P h. After t funera	ion;	27. Manual of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year) 28b. Time o	Wo	iry at ork?	28d. Describe I	how injury occurred	
isio	Attending r death. ector: After y the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be co- Di			Yes 2 No			
Division	ital or A rs after ei Direc led in by	Certification;	4 Homicide determine	ed 286. Place of tr building, e	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tov	Street and Number or Ru wn, State)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the bes eminer: On the basis and manner s	of examination and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	-	7	29c. Licen			29d. Date signed (Month	n, Day, Year)
•	17		700-	eceny 1			57614		1/29/04	
	(0		30. Name and address of person wh				D-c-1- 3	WD 20010	, ,	
	Sta	to.	Don Coleman, M. 31. Date filed (Month, Day, Year)		Carroll Ave	A		MD 20912	<u> </u>	
	Registr	. 9	OCT 04 2	104 Done	was B	Louds	1			

			For State Registrer	State of Marylan	-	artment of I		and Mental Hy	/giene Reg. No.	Management Services	32960		
١	Physici	an	Decedent's Name (First, Middle, Last					2. Date of D Month Octobe	eath Day	Year	3. Time of Death 9:16p M		
	/Medic Examin		Riley Houston I 4a. Facility Name (If not institution, give	Mayhall, Jr. street and number)		4b. City, Town, o	or Location of		4c. Count		9:165		
	LAdiniii	e.	Holy Cross Hosp	ital		Silver	Sprin	q	Monto	omer	y ·		
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		If Under 1 Year Months Days			irth ay, Year)	9. Birthp	place (State or Foreign		
	Director		419 20 9418	ZM 2□F 78	Yrs.			August	29, 1926	Alaba	ma		
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	10d. Inside City Limits		
	Mary I-f sh	ţō	Maryland Montgo	nery Bu	irtons	/ille				•	1 ☐ Yes 2XQXNo		
	3a or 28e	I Director	10e. Street and Number 14130 Old Columb	ia Pike		10f. Zip Code 20866	5		10g. Citizen of USA	What Cour	ntry?		
36	d within 72 hours after death with the Maryland Jiene. I then "neturel", or Items 23a or 28a-f show The Madical Examinant out be notified at	y Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 2 No	an, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)		ce - Americ ick, White,	etc.		
21215-0036	hours turel:	ed by	3 Widowed 4 Divorced 15. Decedent's Edi		VII	dent's Usual Occu	nation		16b. Kind of E		nite		
75	in 72 n "net	olete	(Specify only highest grad	de completed)	(Give	kind of work done DO NOT use retire	during most	of working	TOD. KING OF E	USII 1033/111	,		
212	d within giene. rr then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Engi	neer			Mechani	.cal I	Engineering		
ğ	be filed stal Hygie ed other	BeC	17. Father's Name (First, Middle, Last)					r's Name (First, Middl		ne)			
ylaı	Ments Ments arked atic e	오	Riley Houston Ma				1	ddie Garri					
Maryland	2 short and and less mereum		19a. Informant's Name/Relationship (7) Elfriede Mayhall					r or Rural Route Num.	-		o <i>Code)</i> ryland20866		
e,	1 and Health em 27		20a. Method of Disposition	20b. P	Place of Dispo	osition (Name of	1	Date Date	20c. Location				
ğ	age in of or		1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cre	matory or other pla		October 3,					
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental hy Importent: If item 27 is marked oth eny injury or giher treumatic even once.	li	21. Signature of Funeral Service Licens		2	an Cremato 2. Name and Addre	ess of Facilit		Alexandri		TITIA		
B	per fmp eny		*Annahavid	tarices				ins Funera Avard. West.			Maryland 20901		
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death one cause on each line. aMyocardial	h. Do not en	ter the mode of dyi				J.	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in dealin)	Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of):									
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C C									
o,	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	uence of):								
8760	ate be shysicit	dical		d									
9	artifica ing ph e as ti	Med	IF FEMALE:										
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ysician/	ysician/	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3[□Ectopic pregnand □ Other (specify) _	У			ate of delive onth	ery Day Year
a	res that t igned by be deta	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	ınderlying cause gi	ven in Part I.	23e. Did	tobacco use con	tribute to ti	he cause of death?		
rds,	w requires been sign should be	q pa						1 🗆	Yes 2□No	3 🗆 Prob	pably 4 Unknown		
Record	The law recte has bee age 2 sho	Completed						24a. Wa aut per 1 □ Yes	s an 24b. ppsy ormed?	Were auto prior to co death? 1 \(\subseteq \text{Yes} \)	opsy findings available impletion of cause of		
Vital		a	25. Was case referred to medical				26. Place	of Death (Check only					
of V		To B	examiner? 1 ☐ Yes 2胚 No		ER/Outpatie	nt 3□ DOA Ot	her: 4 🗆 Nu	rsing Home 5 Res	sidence 6 🗆 Ot	ner (Specif	(y)		
			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)				28d. Describe how injury occurred					
Sio	Attending r death. ector: After oy the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	-	omo form et]Yes 2□		(Street and Num	her or Pur	al Pouto Number		
Division	in Direct	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	fy)	reet, ractory, office			own, State)	Jer or Murz	ar riodie rydriber,		
_	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the completely filled in the funeral present the formula of the filled in the fille	Medical C		ysician: To the best of my kno liner: On the basis of examina and manner stated.									
	ro the vithin ro the comple	Me	29b. Signature and title of certifier)		29c. Licen			29d. Date signe				
			1 Cleristoph	aep, m. s.		D3979	3		October	3, 200	14		
	10		30. Name and address of person who										
ò –			Christopher J. Ma			nce Phil:	ip Dri	ve, Suite2	07, Olne	эу, М	D 20832		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 0 4 201	32. Begistrar's Signa	ature	Sparks							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month Madden, Sr. Thomas J. September 30, 2004 6:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Ye 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Months 1 X M 2 ☐ F Yrs. 1918 Director 293-03-8061 85 Dec. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show r then "natural", or items 23e or 28e-f shov the Medical Examinar must be notified at 1 X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1633 Edgewood Place #102 21740 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if itam 27 is marked other then "natural", or ite many or other traumatic avant, the Medical Examina any ping. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WW II à Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Time Keeper 12 Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martin Madden Margaret Feeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Madden / Wife 1633 Edgewood Place #102 Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Oct. 4, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2004 Silver Spring, MD 21. Signa ure o Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Myocardia days /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examine as the burial-transit certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical пsе 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at Id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes I or Attanding Physician: after death. Diractor: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No ^L 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Physicish September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIATHUIZ 4600 Rd Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 04 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 29, Physician 2004 KATHERINE MORRISON 10:30 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE ROCKVILLE NURSING HOME MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Ye NOV 16, I 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 89 1914 ILLINOIS 323-18-7858 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, the Mcdical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3104 BIRCHTREE LANE 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or item eny injury or other traumatic event, the WidGall Examina Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE AGENT REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KATHERINE JAHN CARL NEMETH ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LELANI MCKENNA - DAUGHTER 3104 BIRCHTREE LANE, SILVER SPRING, MD 20906 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State NATIONAL CREMATORY 10/4/2004 FALLS CHURCH, VA * 4 □ Donation 5 □ Other (Specify) gnature of F leral Sen be Licensee 22. Name and Address of Facility AFFORDABLE FUNERAL SERVICE 7400 LEE HIGHWAY, FALLS CHURCH, VA 22042 23a. Part 1. Enter the disease, or comblications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final NEOMORIN Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician ned for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1☐ Live birth 2 ☐ Fetal death
4☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be SEWILE DENEUTLA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu PET HIP FRACTURS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 2 No 1 Yes 2 No 1 Yes completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 12 Yes 2 □ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending PECCUT OF CHAIR 2 Accident ₽M 1 Yes 2 No death. investigation AUGUST 25, 2004 1600 after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 303 AOCLANDE RO 4 Homicide ROCKULE WHOME HOME 2000cinus within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31039 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) CHR:STOPHEN C.

31. Date filed (Month, Day, Year)

OCT 0 5 2004 W. Montgomery AVG. ROOKVILLE, MD. UNSORD

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State Registrar 32. Registrar's S

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iges 1 and 2 should be filed within 72 hours after death with the Maryland to F Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23e or 28e-f show or other traumatic event, the Medical Exprineral must be notified at	by Funeral Director	1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	0	If Yes, specify Cut 1 ☐ Yes 2 X No		erto Rican, etc.)	Black, Wh	_{ite, etc.} H ispanic	
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lid be fenta rked ric ev	To B	Hernan Gar	cia			Mar	ia Magdal	ina Martin	ez	
D = W ->	-	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Stree	t and Number or	Rural Route Numbe	er, City or Town, State,	Zip Code) 20902	
alth a		Jose Carlos Marti	nez (Broth	er) 11.	504 Elkin	Street;	Apt. 103;	Wheaton, l	Maryland	
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ath cer	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal death	3 Ectopic pregnand	су		23d. Date of de Month	elivery Day Year	
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OVISION I or Attending after death. Director: After in by the function	Certification:	3 ☐ Suicide 6 ☐ Could not b		iry - At home, farm	, street, factory, office		28f. Location (S	Street and Number gr F	Ryral Route Number,	
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n 24 I n 24 I ne Fu sletely	edical	(Check only 2 Medicel Exer	miner: On the basis of and manner sta	examination and/o	r investigation, in my	opinion, death of	curred at the time,	date and place, and du	e to the cause(s)	
vithii To th	ž	29b. Signature and title of certifier		00-	29c. Licen	ocmE		29d. Date signed (Mon September		
		Hatil	10-18	Illel	on	OCHE		DEPLEMBET	20, 2001	
2 (1)		30: Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print)	enn Stre	et, Balti	imore, Mary	land 21201	
2	ate	31. Date filed (Month, Day, Year)	2. Registra	ar's Signature						
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	-		1 - State of Maryland / Department of Maryland	artment of Health and Me ertificate of Death	ental Hygien	2001 00001
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
Į,	/Media		Faye A. Murphy		September	26,2004 1:45am M
*	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	Funeral		Fort Washington Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Fort Washington If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Georges
ı.	Director		577-52-0343 1 M X F 67 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year, February 2	9. Birthplace (State or Foreign Country) 25,1937 North Carol
	pu ≥ ∷		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo			
	ahov ed as	ō				10d. Inside City Limits 1√2 Yes 2 ☐ No
	28a-1	Funeral Director	MD Prince Georges Oxon Hil	10f, Zip Code	10c Ci	tizen of What Country?
	3a or	ō	6407 Livingston Rd #102	20745		ed States
	ms 2	Jera		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R		14. Race - American Indian,
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פ	e filed within al Hygiene. I other then " vent, I'le Me	Bec	17. Father's Name (First, Middle, Last)		(First, Middle, Maider	
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Maryland	2 shc and is m			ng Address (Street and Number or Rural		
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Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.	1	The state of the s	Veterans Cem 10-4-		1tenham,MD
Ba	Depa Impo any ir	1	Jacona Jy Cara	^{2. N} Ane and Address of Facility Pope 2617 Penn. Ave., SE	Washing	Home ton, DC 20020
68760,	Attending Physician: The law requires that the death certificate be executed T death. T death. Sctor: After this certificate has been signed by the attending physician and D in positive the funeral director, page 2 should be detached for use as the burial-transit or D in D in D in D in D in D in D in D i	الاسترامة الاسترامة الاسترامة الاسترامة الاسترامة الاسترامة الاسترامة الاسترامة الاسترامة الاسترامة الاسترامة ا	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):	LUNG CANCE	C to Bo	Approximate Interval Between Onset and Death
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	tal or rs afte el Dir ed in	Cerl	4 Homicide building, etc. (Specify)		City or Town, State)
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•	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	29c. License number	29d. Dat	e signed (Month, Day; Year)
0	(10)		30. Name and address of person who mpleted cause of death (Item 23a) (Type, I		1.6	7
	(10)		Dr. Karen McGibbon 5100 Auth Way Suit	tland, MD 20747		(
	Sta Registr		31. Date filed (Month, Day, Year)			
DH	MH 17 Rev 1/20		OCT 0 5 2004 Keeper & April			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Lest) 3. Time of Death October 6 **Physician** 2004 Gary Lee Monninger 8:30 AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington 15030 Clear Spring Road Williamsport If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yes Feb. 18, 9. Birthplace (State or Foreign 5. Social Security Number Year) Months Days Hours 1 XM 2 F Yrs 1946 Maryland 58 212-50-9133 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes Ž☐ No Funeral Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 USA 15030 Clear Spring Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1964-14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give 1970 Year or Dates: 1 Never Married 2 X Married white 1 ☐ Yes 2 ☐ KNo Specify: Specify: ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engine Manufacturer 12 Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Virginia Staley Walter Elwood Monninger, Sr. ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 15030 Clear Spring Road Williamsport, Maryland 21795 Joan A. Monninger - Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Oct.7, 2004 Smithsburg, Maryland 4 Donation Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lie Osborne Funeral Home, P.A. 21795 425 S. Conococheague St. Williamsport, Maryland Approximate shock, or heart falure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Sclerosis Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy 1 Tes 1 ☐ Yes 2 ☐ No 2 € No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify) 1 X Yes 2 □ No Certification: To 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suícide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of portifier D0011266 October 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard N. Weeks, MD 580 Northern Ave. Hagerstown, Maryland 21742

State Registrar

Funeral

Director

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mentel Hygiene. ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other treams.

permit. Page Department of Important: If any injury or once.

Physician /Medical

Examiner

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the attending physician

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After

To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu

Division of Vital Records. P.O. Box 68760.

Baltimore, Maryland 21215-0020

31. Date filed (Month 2004

32. Registrar's Signeture

A. Sperke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29, 2004 **Physician** 9:48 P Thelma Marshall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F Months 60 Director 213-42-7903 November 1,1943 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic evant, the Medical Examiner must be notified at 1 XYes 2 No Maryland Charles Director Pomfret 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 20675 USA 8020 Marshall Corner Road Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Customer Service K-Mart 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Savoy Washington Frank ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8020 Marshall Corner Rd Pomfret, Maryland 20675 Robert Marshall/Husband itam 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of P
Important: If its
eny injury or ot N Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Marys Cath Ch Cem 10/5/04 Clinton, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee affer Adams Funeral Home P.A. Aquasco, Maryland MO1323 ()dessa 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Neutropenia disease or condition resulting in death) /Medical-Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that in the text of the text Due to (or as a consequence or). Examiner use as the burial-transit Hospital or Attanding Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably After this certificate has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation death. 1 Tyes 2 No after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours a Funaral I 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46478 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) adelmo syrratts Red PR

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31. Date liled (Month, Day, Year)

OCT 04

2004

			1- For State of Maryland Registrar	l / Depa		lealth and N	lental Hyg	giene	32967
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Dav Year	3. Time of Death
	/Medi		Arthur Walter Mack				Sept.	30, 2004	7:00 a M
	Examir	ier	4a. Facility Name (If not institution, give street and number) 8111 Forest Glenn Road			r Location of Death Plains		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
	Funeral Director		132-05-7579 10 1 1 1 2 1	Yrs.	Months Days	Hours Min.	March March	30,1919 N	nplace (State or Foreign untry) New York
	how		10a. State 10b. County 10c. City,	Town or Loc	ation				10d. Inside City Limits
	e Ma	cto	Maryland Charles Wh	ite F	Plains				1 ☐ Yes 2 🎇 No
	ith th	Funeral Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	untry?
	s 23a	ral	8111 Forest Glenn Road		2069			U.S.A.	
	item de	ü	11. Marital Status 1 □ Never Married 12 ▼ Married 12 Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No	13. W	as Decedent of F Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
336	irs af	by F	3 Widowed 4 Divorced Year or Dates:	1	☐ Yes 2 XNo	Specify:		Specify: Wh	ite
ò	d within 72 hours after death with the Maryland liene. I then "natural", or items 23a or 28a-f show the Medical Examinational Legiodified at	ted	15. Decedent's Education		ent's Usual Occup			16b. Kind of Business/I	ndustry
218	within 7 ene. than "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use retired	during most of work d)	ing		
21	filed with Hygiene. other than	Con	12 6	Prin	ciple				Education
ng	be be	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam		-	
2	d 2 should be the and Mental the and Mental to is marked of traumetic ever	^L	Frank Mack	405 14-11		Bertha	Vaupe	<u>: L</u>	
Maryland 21215-0036	7 is 7		19a. Informant's Name/Relationship (Type, Print) Lillian Mack Wife	196. Mailing 8111	Forest	Clenn E	d Wh	r, City or Town, State, Z	20695
	s 1 and if Healt item 2 other		20a. Method of Disposition 20b. Place	ce of Disposi	ition (Name of	GICIII P	Date	20c. Location - City or 1	
JO I	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	netery, crema nitv	atory or other plac Memoria	oct 5 al Garde	004	Waldorf,	
Baltimore,	프 는 보고 등		21. Signature of Funeral Service Licensee	-32	Name and Addre	ss of Facility	.115		
ä	Depa Impo any is		Wale Polling MOOG	$68 \begin{vmatrix} w_1 \\ 42 \end{vmatrix}$	111ams 170 Hawi	Funeral thorne R	d. Tn	P.A. dian Head	, Md.2064
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Do not enter	r the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	death certificate be executed XX estending physician and XX dfor use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or its a consequence of the consequence	nce of):	sè al	U			
9	ng ph as th	P	IE FEMALE.						-
P.O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 E	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	very Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulti	ng in the und	derlying cause give	en in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	the cause of death?
Vital Records,	The ate ha	Completed	Choric renal	cee S	edfice	eceop	24a. Was a autops perform	prior to co death?	opsy findings available ompletion of cause of
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital:		Lou	26. Place of Death	(Check only on	(8)	
Tolong	Q is	To.	1 Inpatient 2 EP	NOutpatient 8b. Time of	3□ DOA Oth	4 🗀 indising no		ence 6 Other (Speci	fy)
uo	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year)	Injury	28c. Injun Worl	y at k? Yes 2 □ No	28a. Describe no	ow injury occurred	
Division	Attending r death. sctor: After by the funer	fica	3 Suicide 6 Could not be	e, farm, stree			28f. Location /St	reet and Number or Run	al Route Number
Θ	after after Dire d in b	Certification;	4 Homicide building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	.,, ,		City or Towr	, State)	ar riodio riambol,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and manner stated.	adge, death on and/or inve	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurr	and due to the ca	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier (10)		29c. License	a number	2	9d. Date signed (Month,	Day, Year)
			6. Karocaar		D-00	56949		9/30/0	4
(D let 5		30. Name and address of person who completed cause of death (Item 23	3a) (Type, Pi		20243			
1)	P125		Kamakshi Baig,MD 6620 Crai	n Hwy	Suite	102 La	Plata,	MD 20646	
	Sta Registr	-	31. Date filled (Month, Day, Year) OCT 0 4 2004 32. Redistrar's Signatur	K A	necky				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2200 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear 9:55 AMM **Physician** 6, October 2004 Joseph Aloysius Miles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Lexington Park 21340 Windsor Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X**M 2□F Maryland 53 215-56-9760 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County id 2 should be filed within 72 hours after death with the Marylan thin and Mental Hygiene. 27 is marked other than "natural; or itema 23s or 28s-f show treumatic event, the Medical Exemine must be notified at treumine to work the Medical Exemine transities. 1 TYes 2XXNo Director Lexington Park St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21340 Windsor Drive 20653 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?
1 Ayes 2 No 197 11 Marital Status Black, White, etc. 1 Never Married 2 Married within 72 hours after 1972-1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Electric Company Warehouse Stockhandler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Barnes Joseph Henry Miles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21340 Windsor Drive Lexington Park, Maryland 20653 f Health item 27 i Robin Miles / Wife other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
important: if ite
any injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-9-04 Lexington Park, MD Immaculate Heart 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral S Mo/095 22955 Hollywood Road Leonardtown, MD 20650 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death 23a. Perf1. Enter the dise shock, or heart faily Immediate Cause (Find ADENO LATELINOMA -4 months METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) PIIMART Examiner UNKOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a sunsequence ut). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 nding physician Physician/Medical the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Tyes 2 No P.0. the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 0 No 3 Probably 4 □Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) efter death.

Director: After this certification by the funeral director. 25. Was case referred to medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 块卷 1018 64 0 50696 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, 25500 Point Lookout Road Leonardtown, Maryland 20650 Gurdeep Chhabra, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

32. Registrar's Signature

2004

			For Stete Registrar		State of Ma	aryland /		artment of H			-	giene Reg. Ng. ()	Manage of the second	32969
			1. Decedent's Name	e (First, Middle, La	st)						Date of De	ath		3. Time of Death
	Physici /Medic		Elsie	M. Mon	k					15	epten	nber 2	-8.2004	1 07:32AM
	Examin		4a. Facility Name (II	f not institution, giv	e street and number)			4b. City, Town, or	Location		1		unty of Death	
			6000 9	amavi	tan Hos	pita	1	Balti				1	A	
	Funeral		5. Social Security N		ex 7.Ag □M 252F	e (In yrs. last		if Under 1 Year Months Days	If Unde Hours	Min. 8.	Date of Bir (Month, Da	th y, Year)	9. Birthp	place (State or Foreign
	Director		577-48-	-8569	LIW ZE	95	Yrs.			Ar	ril 1	5,1909		WV
	and		Usual Residence of 10a. State	10b. County		10c. City, To	own or Lo	ecation					1	I Od. Inside City Limits
	Many f sh	ğ	MD	Anne A	rundel			Ann	apol:	is				1 ☐ Yes 2 ☐ No
	1 the	Funeral Director	10e. Street and Nun	mber				10f. Zip Code				10g. Citizen	of What Cour	ntry?
	3a o	<u>-</u>	1211 Ra	mblewood	Drive			2	1401				USA	
	ms 2	Jerg	11. Marital Status		12. Was Decedent		13.	Was Decedent of Hi If Yes, specify Cuba		rigin? (Specify	Yes or No		Race - Americ	
Maryland 21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-f show of Examinar must be roulified at	ρ	1 ☐ Never Marri 3 🙀 Widowed	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	irYes, specify Cuba 1□Yes 2√2No	n, Mexica Specify		an, etc.)	İ	Black, White, ec <i>ify:</i> Wh	etc. Lite
9	be filed within 72 hours tal Hygiene. d other then "natural; avant. Its Medical Exa	Completed	(Spec	15. Decedent's Edify only highest gra		16	6a. Dece	dent's Usual Occupa	ation	et of working		16b. Kind	of Business/Inc	dustry
21	within and the state of the sta	lg.	Elementary/Secon		College (1-4or 5	5+)	life.	DO NOT use retired)	st of working				
2	e filed within al Hygiene. I othar than vant. The Wa	S			4		Admi	nistrativ						vernment
nd	tal Hid oth	Be	17. Father's Name (ner's Name (F				
₹		ပ		Miller Br						ncy Ell				
Jar	S S S S S S S S S S S S S S S S S S S		19a. Informant's Na	me/Relationship (chard C.]				ng Address (Street a					wn, State, Zip	Code)
	1 and 1 and 1 and 2 and 2 and 2 ther		20a. Method of Disp		MOTIK/ SOIT		-	Oak Lane,	TOW	SON, ML			ian City as Ta	num State
Baltimore,	of of		1 🔀 Burial 2 [☐Cremation 3 ☐	Removal from State	ceme	itery, crei	natory`or other plac	· 1	Oct. 1			ion - City or To	
語	permit. Pag Department Important: I any injury c		* 4 □ Donation 21. Signature of Full	5 Other (Specif		Lake		t Cemeter	_	20	004		dsville	•
Ba	permit. Pag Department Important: I any injury o		Mom	4790	ln		4	95 GOV. R	itch.	ıе нwy,	Seve	erna P	ark Fur ark, MI	neral Home 21146
	Pnysician /Medical		23a. Part1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List only Final	plications that caused one cause on each ti	My Ai	ter	er the mode of dying			spiratory ar	rest,		Approximate Interval Between Onset and Death
H	Examiner	<u></u>	Sequentially list cor	nditions,	b. Atvial	a consequence	ovil	lation						two years
	ted nsit	Examine	if any, leading to im cause. Enter Under Cause (Disease or i	rlying	Due to (or as	a consequent	J o 01).							
	icate be executed physician and s the burial-transit	xar	that initiated events resulting in death) L		c Due to (or as	a consequenc	ce of):							
8760	siciar siciar b buri	dical		l	d									
9	ifficat g phy as th	a l												
.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12: 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea	ath 3	Ectopic pregnancy Other (specify)				23d.	Date of delive Month	ery Day Year
Q.	that		Part II. Other signifi	icant conditions of	ontributing to death b	ut not resulting	g in the u	nderlying cause give	n in Part	l.	23e. Did to	bacco use	contribute to th	ne cause of death?
Vital Records,	quires n sign ald be	ed by	Demen	110							1 □ Y	′es 2 ⊠N	o 3 Prob	ably 4 Unknown
00		Completed	GRIZIAN	P. Dic	order						24a. Was	an 24	4b. Were autor	psy findings available
Re	e ha	E O	COLDIA	•	er							rmed?	prior to con death?	npletion of cause of
ta		a)	25. Was case refer			,			26. Place	e of Death (C		2 PNo	1 🗆 Yes	2 NO
	ysic is ce dire	0 B	examiner? 1 Tyes 2	₩o	Hospital: 1 Inpatie	nt 2 ER/	Outpatien	t 3 DOA Othe					Other (Specify	1)
J Of		n: T	27. Manner of Death		28a. Date of Inju (Month, Day	ry 28b	. Time of	28c. Injury Work		7,000		ow injury oc		,
<u>Ö</u>	Attanding r death. octor: After by the fune	atic	2 Accident	5 Pending investigation	1		,,		/es 2□	No				
Division	il or Attand after death I Director: / d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of Inju- building, et	ury - At home, c. (Specify)	farm, str	eet, factory, office		28f.	Location (S City or Tow	Street and Nu	umber or Rura	l Route Number,
	ital o													
	To the Hospital or a within 24 hours atter To the Funeral Direct completely filled in E	edical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exer	ysician: To the best niner: On the basis of and manner sta	examination :	lge, death and/or inv	n occurred at the time vestigation, in my op	e, date ar sinion, dea	nd place, and ath occurred a	due to the o	cause(s) and date and pla	manner as sta ce, and due to	ated. the cause(s)
	To the within 2. To the complete	Ž	29b. Signature and	title of certifier				29c. License	number		1	29d. Date si	gned (Month, L	Day, Year)
				De	VIX	m	1)	D000	170	15		epte	mber	29,2004
			30. Name and addre	47	completed cause of d				1. 1	Da :-	#	7 17	. / 1 :	MD
			Ebenez		11100 54		ch 1	aven t	iva	POB	130	5, 150	altimo	DIE 2123
	Sta Registr		31. Date filed (Mont	SEP 3 0		ar's Signature	4		'					
DH	MH 17 Rev 1/2	_		321 0 0	- July	את השיעו	1	para)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Edward 2004 1:20 a M Thomas Patrick October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Port Deposit Cecil Residence: 165 Craigtown Road 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F Yrs. 212-34-5883 68 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tems 23a or 21904 U.S.A. 165 Craigtown Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status filed within 72 hours after 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1961–63 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: δ White 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State Highway Administration College (1-4or 5+) Elementary/Secondary (0-12) Highway Maintenance Supervisor Rising Sun, Maryland Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tent: If item 27 is marked other th jury or other traumetic event, Its. Twelve Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Garrett Patrick Oma Florence Pennington ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith Ann Patrick (wife) 165 Crai town Road, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. West Nottingham Cemetery 10/05/04 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ucensee Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non-small Cell Physician ung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death signed by the at d be detached for 5 Other (specify) of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan page 2 1 Yes 2☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☐ No Alter thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: Al
completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO053675 MD 1104 obet (1//lantellen e Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III W. High St. Svite 214. Elleton, MD Monteleone, MD 32. Registrar's Signature State Registrar

			1 - For State Registrar		Marylan		artment rtificate					eg. No.?	and the second of the second o	329	7
	Physici	an	Decedent's Name (First, Middle								2. Date of Deat Month	Day	Year	3. Time of (Death
	/Medic			Patrick Elw		inn					October	2, 2	004	1409	. M
	Examin	er	4a. Facility Name (If not institution Residence: 67				4b. City, To					4c. County			
			5. Social Security Number	North Main		last birthday)	If Under 1		Depo		8 Date of Birth		Ceo		Enroian
	Funeral Director		544-26-2552	10XM 2□ F	77	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, July 13	Year) 1927	Cou	place (State or htry) LSCONSI	roreign
			Usual Residence of Decedent									, 1,2,1		LOCOIISI	11
	anylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City	
	8a-f	ecto		cil					Depo	sit				1 🔯 Yes	2 1140
	with t a or 2	급	10e. Street and Number 67 North Main	Stroot			10f. Zip C		1904		1	0g. Citizen of V		•	
	death with the Marylanns 23a or 28a-f show	Funeral Directo	11. Marital Status	12. Was Decede	nt Ever in U.	.S. 13. V	Was Deceder			in? (Spec	cify Yes or No-		U.S.A	an Indian,	
0	after des or Items	臣	1 ☐ Never Married 2 🛛 Mar	ried Armed Force	s?	į.				Puerto P	cify Yes or No- Rican, etc.)		k, White,		
2-003p	rel', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s: 1943-	-51	1 ☐ Yes 2 ☐	XI No	Specify:			Specify	· WI	nite	
ה	filed within 72 hours after death with the Maryland Hygiene, Hydiene, or Items 23a or 28a-f show sit, it e Madical Examiner must be malified a	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Deced	dent's Usual (kind of work DO NOT use	Occupat done du	tion uring most o	of workin	g n	16b. Kind of Bu			
V	within ane. then	m	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	Truck					Cri Stat Elkton,		_	
2	be filed within tal Hygiene, ad other then event, it a M	e Co	Twelve Years 17. Father's Name (First, Middle,	Last)			TIUCK			's Name	(First, Middle, A		<u>-</u>	rand	
yiand		To B	Lloyd	Elword Quin	n					Sc	olona Ad	laline S	Stock	r	
	2 should be and Mental Is marked aumatic ev	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (S	Street ar	nd Number		Route Number,				
≥	5 # Z E		Geraldine B. Q	uinn (wife						et, F	ort Dep	osit, 1	1ary]	land 21	904
(I)	es 1 a of Head Hitem		20a. Method of Disposition 1 ☐ Burial 2 Cremation	3 ☐ Removal from Sta	20b. P	lace of Dispo emetery, cren	sition (Name natory or othe	of er place,) !			20c. Location -	City or To	own, State	
Ē	Pag Iment tant; jury c		' 4 ☐ Donation 5 ☐ Other (S	pecify)		. Ferris	& Co.,	Inc	• 1	.0/08		est Chesi	er, F	Pennsylva	mia
Бащто	permit. Pages I Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service	Licersee	. 1		Name and	Address Pat	of Facility terso	n &	Son Fun	eral Ho	ome,	P.A.	
		1 22	23a. Part1. Enter the disease, or	complications that cause	sed the death		erryv	ттте	, Mar	ylar	id 2190	3-0/66		Approximate	
١,			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	MM1 i.	~A				. oopiiatory arro		jt	Interval Between Onset and De	
Г	mysician /Medical		disease or condition resulting in death)	a. Doe to (or	as a consequ	pence of):	MINI	_			-		-		
	Examiner			1 Den	mont	N									
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):									
	and trans	Examiner	that initiated events resulting in death) Last	c. XY	as a consequ									· · · · · · · · · · · · · · · · · · ·	
,00,	rate be executed hysician and the burial-transit	Ical E		out to (or	as a consequ	derice of).									
90	Ine law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	edlc		d.											
X	leath certifica attending ph	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d. Date	of delive	ery	
0	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of de		Ectopic preg Other (spec					Mon		Day Ye	ar
ν. Ο	at the	hys	9 🗆 Unknown												_
,	w requires that the de been signed by the s should be detached	þ	Part II. Other significant condition	ons contributing to death	but not rest	ulting in the ur	nderlying cau:	se given	in Part I.			acco use contri			
cords	requi	eted	- ICHON O	111111	- 17						1 U Ye	s 2 No	3 Prob	abiy 4 🔯Un	known
ည မ	e law has t je 2 s	Completed	amemon 10	45hh5-						_	24a. Was ar autopsy perform	r DI	ere autor rior to cor eath?	psy findings av npletion of cau	ailable ise of
	sician: The lav certificate has rector, page 2		25. Was case referred to medica								1 ☐ Yes 2	X No 1		2 No	
5	s certi	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2 🗆	ER/Outpatien	+ 3□ DOA				(Check only one e 5 ☑ Reside		- /Cassif	ADDR	100
5	g Phy er thi	n; T	27. Manner of Death	28a. Date of In		28b. Time of		. Injury a Work?	at True	28	d. Describe ho	v injury occurre	id	7	
SION	death. ctor: Aft y the fur	atlo	1 ✓ Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	Jay (Gai)	Injury	М		es 2 □ No	0					
<u>"</u>	r Atterder de irecto	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 289, Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory, o	ffice		28	of. Location (Str. City or Town,	eet and Numbe State)	r or Rura	Route Numbe	er,
ָ ב	Hospitel or Attending Physician: 44 hours after death. Funerel Director: After this certificately filled in by the funeral director,		177.0-161	- 5						+					
	To the Hospitel or Attending Physician: The within 24 hours after death, within 24 hours after death, To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☑ Certifyir (Check only one) 2 ☐ Medicel	g Physicien: To the be Exeminer: On the basis and manner	of examinat	wledge, death tion and/or inv	estigation, in	the time my opir	, date and nion, death	occurred	nd due to the car d at the time, da	use(s) and mar te and place, a	ner as st nd due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signafure and title of certifie	r			29c	icense i	umber		29	d. Date signed	(Nonth, I	Day, Year)	
	\		Hi sup G	iM			11,	14	041	1		10 4	TEL	f	
) or A	ſ	30 Name and address of person	who completed cause	death (Item	23a) (Type, I	Print)		Anh		Mini	1	hin	211	28
	Sta	4	31 Date filed (Month, Day, Year)	324890	strar's Signal	ture V	WIN	- (NVU		4/1/	s VV	W)	10	70
	Registr	_	OCT 5	2004	w L	4	de								

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		•	giene Reg. No.?	11. 32972
			Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ath	3. Time of Death
	Physici /Medic	10	Leo Roik						Day ber 05, 20	Year 02:20 A M
	Examin		4a. Facility Name (If not institution	n, give street and number,		4b. City, Town, o	r Location of Death		4c. County of	
			Saint Vincent de	aul Nursing Ca	re Center		Frostburg If Under 24 Hrs.		Allego	iny
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day	h y, Year)	Birthplace (State or Foreign Country)
	Director	-	219-16-7895 Usual Residence of Decedent		78			28-Nov-	-1925	Maryland
	show		10a. State 10b. County		10c. City, Town or L	ocation		· · · · · · · · · · · · · · · · · · ·	····	10d. Inside City Limits
	Many Fish	ţō	Maryland All	egany	Frostburg					1 Yes 2 □ No
	r 28e	Director	10e Street and Number	Barnard Street	TROSIDOIG	10f. Zip Code			10g. Citizen of W	hat Country?
	th wit	alD	213	baniara sireer		21532-			U.S.A.	
	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No- Rican, etc.)		- American Indian, c, White, etc.
36	or It	by Fu	1 Never Married 2 Marr	If Yes, Give		1 ☐ Yes 2 📈 No	Specify:		Specify:	
Ö	hours tural		3 Widowed 4 Divorced	Year or Dates:		edent's Usual Occup	antion		16b. Kind of Bus	White
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or Items 23a or 28e-f show the Madigal Examere must be notified at	Completed	(Specify only highe	st grade completed)	(Giv	e kind of work done DO NOT use retired	during most of work	king	TOD. KING OF DUS	sines windustry
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4or		odian			high school	ol
	illed Hygid other	ø	17. Father's Name (First, Middle,		7 COSI	Odidii	18. Mother's Nan	ne (First, Middle,		
<u>a</u>	Mental Merked o	To B	Joseph Flisak				Sophie R	oik		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla It of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28e-1 show or other treumatic event, the M. Affed Exatr ther must be rediffied at		19a. Informant's Name/Relations	hip (Type, Print)	19b. Mai	ling Address (Street			r, City or Town, S	State, Zip Code)
	1 and 2 Health tem 27 i		Linda Lewis	niece		9 Old Troutma	in Lane, Fra	stburg	Mary	
ore	of He		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of amatory or other plac	ce)	Date	20c. Location - 0	City or Town, State
Ë	Pa ant ary		'4 □ Donation 5 □ Other (S			el's Cemetery	08-	Oct-2004	Frostburg	Maryland
Baltimore,	permit. Pages 1 and i Department of Health Importent: If item 27 any injury or other tr once.		21. Signature of Funeral Service	Licensee	1	22. Name and Addre	ss of Facility			
	70 E 9 9		John)	Much		Ourst Funeral				
			23a. Part 1 Enter the disease, or shock, or heart failure. List	only one cause on each	d the death. Do not er line.	nter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician	î j	Immediate Cause (Final disease or condition resulting in death)	a. acute	ceremu	l infar	ction			one month
1	/Medical Examiner	-	resulting in death)	Due to (or a	s a consequence of):					1
в	Zxammo	10	Sequentially list conditions,	b. Due to (or a)	s a consequence of):					
	ted 1sit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<						
In.	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical								
687	ificate g phy as the	0		u.						
Box	leath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Π -			23d. Date	of delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		□Ectopic pregnancy □ Other (specify)	·		Mon	th Day Year
P.0	tt the by the tache	hys	9 🗌 Unknown	9□ Unknown						
	 requires that the death been signed by the atte should be detached for 	Completed by Physician/M	Part II. Other significant conditi	ons contributing to death	but not resulting in the	underlying cause giv	ren in Part I.		_	bute to the cause of death?
Records,	aquir en si ould l	ted						1 🗆 Y	′es 2 □ No	3 Probably 4 Unknown
ecc	law r as be 2 sh	ple						24a. Was autop	an 24b. W	/ere autopsy findings available rior to completion of cause of
E .		Con						perfo		eath? □ Yes 2 KNo
Vital	ysicien: The lav is certificate has director, page 2	Be	25. Was case referred to medica examiner?				26. Place of Dea	th (Check only o	пе)	
) t	S D	²	1 ☐ Yes 2 No	Hospital: 1 Inpat		ent 3 DOA			lence 6 Othe	
ū	ing P	on:	27. Manner of Death 1 XNatural 5 ☐ Pendir		ury 28b. Time ay Year) Injury	Wor	rk?	28d. Describe h	now injury occurre	ed
Division of	Attending r death.	Certification:	2 Accident investi	not be 380 Place of Ir	njury - At home, farm, s		Yes 2 □ No	28f Location /9	Street and Numbe	or or Rural Route Number,
Σ	or A after of Direction by	artif	4 Homicide determ		tc. (Specify)	iteet, factory, office		City or Tox		or riarar rioble ribriber,
_	Hospitel 14 hours a Funerel I	2	29a, Certifier 1 Certifyii	ng Physician: To the bes	t of my knowledge, dea	ath occurred at the time	me, date and place	and due to the	cause(s) and mar	nner as stated
	24 h	edical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examination and/or i	nvestigation, in my o	pinion, death occu	rred at the time,	date and place, a	nd due to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifie	- 19		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	LITTUA) wonses	Allin	MD	poo	055325	-	oct o	5,2004
	1/1011		30. Name and address of person		death (Item 23a) (Type	e, Print)				
S	nws		wonsode s		48 TO	un Tei	ruce	Frostk	ility !	HD21532
		atė	31. Date filed (Month, Day, Year,	32. Regis	trar's Signature	Spark	/		0	
	Regist	rar	OCT 0 6	ZUU4 /	/-	//				

		1 - State Registrar Amend#5, per	State of Mar						Reg. No	0001	329	73
Physici /Medi	cal	Decedent's Name (First, Middle, Last) Forest Eugene Rip1 4a. Facility Name (If not institution, give state)			4h Cin	Town, or Lo	nation of Don	2. Date of De Month OCtobe	Day		3. Time of 0	Death P M
Examir Funeral	ier	Frederick Memorial 5. Social Sequity Number 6. Sex	Hospital	(In yrs. last birthday	Fred	erick	Under 24 Hr	S. 8. Date of Bi	th	rederick	place (State or	r Foreig
Director	-	Usual Residence of Decedent 10a. State 10b. County		84 Yrs. 10c. City, Town or L	ocation			Nov. 12	, 19	019 Ohio		
r the Marylan r 28e-f show reciling at	Director	Ohio Union 10e. Street and Number		Marysvill		o Code			10g. Cit	izen of What Cou	1 🗆 Yes	
be filed within 72 hours after death with the Maryland klal Hygiene. d other than "natural", or flems 23s or 28e-f show event, I're Medical Evanition into the rivilling at		19303 Raymond Road 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1		430 Was Dece If Yes, spe	dent of Hispa cify Cuban, N	nic Origin? (fexican, Pue pecify:	Specify Yes or No rto Rican, etc.)	USA	14. Race - Americ Black, White, Specify: Whit	etc.	
od within 72 hours afi giene. er then "natural", or i, tre Medical Erani	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+	(Give	kind of wo DO NOT L	al Occupation ork done durin use retired)	ng most of w			ind of Business/In		
be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last) Forest Ripley	3	Autom	ob1le			ame (First, Middle		Sumame)		
nd 2 :		19a. Informant's Name/Relationship (Ty) Tim Ripley, son	oe, Print)	1008	Bexh	ill Dr		rederic	c, MI			
Pages nent o ent: If i		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Liceper		20b. Place of Disp cometery, cre Oakdale	matory or lemete	ery		9/2004	Mar	ysville, sford Fur	Ohio	Iomc
permit. Departm Importe any inju		23a. Part1. Enfer the disease, or complishock, of heart failure. List only or	Bug- cations that caused the	M00999	106 E	ast Ch	urch S	Street, I	rede	erick, MI)1
/Medical Examiner private properties of the private pr	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or i, jury that initiated events resulting in death) Last	COPD Due to (or as a	ory Failu consequence of): consequence of): ve Heart consequence of):	W 0 1 42342	re					Onset and Do	Sali
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	⊒Ectopic p ⊒ Other (s _i				:	23d. Date of delive Month	,	ear
w requires that I been signed by should be deta	by	Part II. Other significant conditions cor Renal Failure		not resulting in the			Part I.	1 🗆	Yes 2	ise contribute to th	abiy 4 XUr	nknow
icien: The law certificate has l rector, page 2 s	e Completed	25. Was case referred to medical						1 ☐ Yes	osy ormed? 2 X No	death?	psy findings av mpletion of car 2 No	vailabli use of
Phys r this ral di	To B	examiner?	ospital: 1 X Inpatient 28a. Date of Injury (Month, Day)	t 2 ER/Outpatie 28b. Time of Injury	-	Other: 28c. Injury at Work?		eath (Check only of Home 5 Resi 28d. Describe	dence (6 □Other (Specify y occurred	Y)	
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, si (Specify)	reet, factor	y, office		28f. Location (City or To		d Number or Rura)	l Route Numb	er,
To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29a. Certifier 1X Certifying Physical Check only one) 1 Medical Examination	sician: To the best of ner: On the basis of e and manner state	examination and/or in	th occurred ivestigation	at the time, on, in my opinion	late and place on, death occ	e, and due to the curred at the time,	cause(s) date and	and manner as si place, and due to	ated. the cause(s)	
You with Tot	Σ	29b. Signature and title of certifier D. Agy	are wir	coda		c. License nu 006200		C		e signed (Month,		
G		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type		Freder	ick, M	iaryland	2170	1		
Sta Regist	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		boux		<i>y</i>				

A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Susan Gresko Roskos Oct. /Medical 2004 10:08 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons, Maryland Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X**X Days Months Hours Min Yrs. Director 284-03-3181 July 15, 1907 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 7 is marked othar than "natural", or itams 23a or 28a-f show traumatic avant, the Medical Examener must be notified at 10d. Inside City Limits 1 Tyes 2X No Directo Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45502 Longford Way 20634 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes X No If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 12th Seamstress Dress Maker th and Mental Hv. 7 is mark. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should t Department of Health and Ment Important: If tem 27 is marked Andrew Gresko Susie Hlavac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Gaulke / Friend 45502 Longford Way Great Mills, Maryland 20634 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or ^ 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 10/12/2004 Charlotte Hall, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brinsfield Funeral Home, P.A. any 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or committee that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congeslive Physician Hearl weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit To tha Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon ō Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð perlense 1 ☐ Yes 2 ☐ 6 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 22 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner' 1 ☐ Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 DiNatural 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To tha Funaral C

completely filled i 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 10 6 11 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road, Suite 203 Prince Frederick, Maryland 20678
32. Register's Signature Anwar Munshi State 1 2 2004 > Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Year OCTOBER 1, 12:40 A M 2004 ROSE SLONIN /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON MONTGOMERY ROCKVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APRIL 19, 5. Social Security Number Birthplace (State or Foreign Country)
 POLAND 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 577-56-7088 98 1906 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits יטינים: וו נופוח צו / 27 is marked other than "naturel", or frems 23a or 28a-f show injury acother treumstic event, the Medical Evantret must be notified at each 1√2 Yes 2 □ No Directo MONTGOMERY ROCKVILLE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6121 MONTROSE ROAD 20852 UNITED STATES by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: 3 Vidowed 4 □ Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental "UNKNOWN" MORUSHNICK SARAH MAX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 | NATHAN SLONIN, SON 2334 SAILFISH COVE DR., W. PALM BEACH, FL 33411 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial Cremation 3 ☐Removal from State Department Important: If any injury o * 4 ☐ Donation | 5 ☐ Other (Specify) NATIONAL CAPITAL HEBREW 10/4/2004 CAPITAL HEIGHTS, 21. Signature of Funeral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 13R **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by EN SION 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 [] No 2 No 1 Yes 1 TYes or Attending Physiclan: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3☐ DOA Other: 2 100 Certification: To 1 Yes 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 04 Agad onde 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Lydia 29**,** Hubchenko Sistrunk September 2004 4:30 A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kensington Nursing and Rehab. Center Kensington

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Director 125-09-6980 Yrs. 84 May 28, 1920 NY Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumetic event, it is Medical Evergrant matter rotation and onge. 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2x No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4043 Adams Drive 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖸 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 10 Peter S. Hubchenko Martha Grembo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy A. Moore/Daughter 4043 Adams Drive, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cem. 10/13/04 Arlington, Virginia 22. Name and Address of Facility DeVol Funeral Home 21 Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Sepsis /Medical Due to (or as a consequence of): **Examiner** Osteomyelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical use IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 21 No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Certification; To Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of 0 29c. License number 29d. Date signed (Month, Day, Year) DO057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D., 13219 Executive Park Terrace, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 04 2004 Registrar DCT

			1 - For State Registrar	State of Maryla			Health and		giene	4 32977
	Physic	ian	Decedent's Name (First, Middle, La	ŕ				2. Date of Do	eath Day	3. Time of Death
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			Laurel Regional			Laur				George's
п	Funeral Director		5. Social Security Number 6. S 577-20-9004	Sex 7. Age (In yr.	s. last birthday,	If Under 1 Year Months Days		n. (Month, D	rth ay, Year)	Birthplace (State or Foreig Country)
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	72 hours after death with the Maryland naturel; or tteme 23e or 28e-f show ite. Executed to ust be nettited at	2	10a. State 10b. County	10c. C	City, Town or Le	ocation				10d. Inside City Limits
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	th with	Funeral Director	5330 Dorsey Hall	Drive Apt. 2	214		042		USA	That Godffiny?
	teme teme	uner	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of I		(Specify Yes or No	- 14. Race	- American Indian, , White, etc.
20	rs afte	by F	1 ☐ Never Married 2 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 GYes 2 □ No If Yes, Give Year or Dates: WW I		1 ☐ Yes 2 ☑ No		, , , , ,	Specify:	
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	and Balth n 27		Daniel G. Scafone			Columbia	a Road	Ellicot	t City,Ma	aryland 21042
ballillore,	00-1-		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	Place of Dispo cemetery, crei ate of	sition (Name of matory or other pla	ce)	Date	20c. Location - 0	City or Town, State
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	/Medical Examiner		resulting in death)	a. Coronary Ar Due to (or as a conse		rsease				Many Years
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	within 24 hours after or to the Funerel Dir completely tilled in a	Medical	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kniner: On the basis of examinated and manner stated.	owledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and plac pinion, death occ	e, and due to the ourred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
i	within 2 To the I	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Month, Day, Year)
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	1		30. Name and address of person who			<i>'</i>				
	Sta	te	R. G. Bhojraj, M. 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 🤌		(Maryland	20707	
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			1 - For Stata Registrar	State of Ma		/ Depa		of H	ealth a			_	o i	00070
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ji.	/Medic		WALLACE A. 4a. Facility Name (If not institution, giv	a street and number)	SMIT	П	4h City T	fown or	Location of		Septemb		2004 by of Death	4:30 a [™]
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	ylan		10a. State 10b. County		10c. City,	Town or Lo	cation						1	Od. Inside City Limits
	Mar Be-f s	io	Maryland Charles		Wald	dorf								1 ☐ Yes 2X No
	h the	Director	10e. Street and Number				10f. Zip (Code			10	g. Citizen of	What Cour	itry?
	th wil	a D	11166 Sewickley	Street			20	0601				U.S.A		
	dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. \	Vas Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
9	or Hr		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛣 N If Yes, Give	40		Yes 2			, 1 40110 1	noan, oto.,		ack, White,	
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	1 and Healt em 2 ther		Kimberly Kibler - 20a. Method of Disposition	Daughter	20h Plac	11166	Sewij	ickl	ey St		, Waldon			
Ö	ges It of H If ite		1 X Burial 2 ☐ Cremation 3 ☐		cem	netery, cren	natory or oth	her place			1.5	Oc. Location	-	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23s or 28e-1 show with injury or other traumatic svent, if a Munical Exercitant: as Le inclination once.		`4 □Donation 5 □Other (Specif		Fort						/2004 E			
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P.O. Box 687	death certific e attending p ed for use as l	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal de time of deat	eath 3 L	Ectopic pre	cify)				М		Day Year
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Vital	Physicien: rthis certific ral director,	Be	25. Was case referred to medi 1 examiner?	Hospital:				Other			(Check only one			
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	ding Ph h. After th funeral	lo	1 Natural 5 Pending	(Month, Day	Year)	Injury	M 20	c. Injury Work	at ? es 2.⊟N		8d. Describe hov	v mjury occur	rrea	
Sic	Attending ir death. ector: After by the fune	icai	2 Accident investigation 3 Suicide 6 Could not b		in. At home	a farm etre			65 Z [[]		8f. Location (Str.	ant and Numb	har at Own	. Causa Musahar
Division	l or Attendater deatl Director:	Certification:	4 Homicide determined	building, etc	. (Specify)	s, iaim, sue	et, ractory,	OHICH		2	City or Town,		Der OF Murai	Houle Number,
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	Registr	1	31. Date filed (Month, Day, Year) OCT 0 5 2004	32. Registra	Appe	le								

04-06299 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ FUI	ertificate of Death Reg. No. 1 1 2 2 2 2 2 2
	Physici	an	1. Decedent's Name (First, Middle, Last) Yancie L. Smith, II	2. Date of Death Month Day SEPTEMBER 30, 2004 5:55P. M
, k	/Medic	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. Country of Death
			8104 CLAY DRIVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	FORT WASHINGTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birthplace (State or Foreign)
ŀ	Funeral Director		215–19–2093 1XIM 2 F 22 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) May 12,1982 Wash., DC
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	
	Mary B-f sho	tor	MD Prince George's Oxon	Hill 1∑Yes 2□No
	with the	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country? 20745 USA
	ms 23	Funeral	308 Brockton Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specify Yes or No-
980	72 hours after death with the Maryland Instural, or Itams 23a or 28a-f show diest Examinat must be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	It Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify: Black White, etc. Specify:
21215-0036	"natur	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)
2121	within piene. r than "	omp		nemployed
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appring yor other traumatic evant, the Medical Examiner must be notified at once.	To Be C	17. Father's Name (First, Middle, Last) Yancie L. smith, Sr.	18. Mother's Name (First, Middle, Maiden Sumame) Valerie J. Caldwell
Maryland	and 2 shou ealth and N n 27 Is mar ear traumal			ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madison St Riverdale, MD 20737
nore,	Pages 1 and 2 nent of Health int: If item 27 I		1 & Burial 2 Uremation 3 Hemoval from State	osition (Name of phace) 10/09/2004 incoln Cemetery Date 20c. Location - City or Town, State Bladensburg, MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatu and Fur eral Service Licensee	2. Name and Address of Facility Tyrone, J., Young Funeral Services
			23a. Part / Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line	19 Kennedy St. W Washington, IC 20011
¥.	Physician		Immediate Cause (Final disease or condition Multiple Gunsho	Wounds To The ited Onset and Death
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らり	To tha within 2. To tha complet	Mec	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
•			Vamet Burthall, MI	O.C.M.E. OCTOBER 1,2004
			30. Name and address of person who completed cause of death (Item 23a) (Type Painela E. Southail, MD	111 Penn Street, Baltimore, Maryland 21201
:	Sta	_	31. Date filed (Month, Day, Year) OCT 0.5 2004 32. Registrar's Signature	

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				OCT 07 2	2004 Seem .	H. A.	sele			~	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October Da SNYDER Year TOUN MUIN 4:50 AM 6,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death CT. 2178 FREDERICK BELLEMONTE JEPFERSON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 24, 1919 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Months Hours 214-09-4145 Min 84 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examinant must be notified at Funeral Director Maryland Frederick **Jefferson** 1 Yes 2 Xo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2178 Bellemonte Court Itams 23a 21755 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Itams 23, ury or othar traumatic event, the Medical Excition or mast 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Xes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: white Completed by WW II 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) engineer railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George R. Snyder ျှ Julia Cashman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce K. Snyder - wife 2178 Bellemonte Court, Jefferson, Md. 21755 20a. Method of Disposition
1 □ Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any njury or once. 4 □ Donation = 5 □ Other (Specify) Cedar Lawn Mem. Park 10/9/04 Hagerstown, Md. 21. Signature of Funeral Service License Name and Address of Facility MINNICH FUNERAL HOME 🚜 15 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Pnysician HEART PHILURE 2 weeks /Medical Due to (or as a consequence of): **Examiner** CORONARY MANY TENTS KILTER Y DITEHTE Separaticity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHUCER. NON SAME CELL 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 No Il Director: After this od in by the funeral of 27. Manner of Death Certification; 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled i 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D D16675 6,2004 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) BRUNSWICK M.D. MD 21716 MUGHER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 7 2004 5 Bellen Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** Shirley Jane SMITH 13:12 AM October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Months Hours Min 65 Director 215-36-6421 3, 1939 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumetic event, I've Mudical Examiner roust be notified at Director 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 14324 Daley Road or Items 23e 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 ☑ No f Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) nurses aide nursing home ges 1 and 2 should be filed v t of Health and Mental Hygie If item 27 ts marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roger Albert Flook Beulah Naomi Stottlemyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard E. Smith - husband 14324 Daley Road, Hagerstown, Md. 21740 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If itel
any njury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery * 4 □ Donation 5 □ Other (Specify) 10/11/04 Hagerstown, Maryland 21. Signature of Funeral Service Licens 2. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner solie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? þ þe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ⊀ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death te of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending 5 Pending investigation 1 Natural death. 2 Accident rector: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier a and address of person who completed cause of death (Item 23a) (Type, Print) AL OT. ASHA MO 1122 VII 31. Date filed (Month 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8:15 PM Dorothy Pearl Smith /Medical September 30,2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death **Examiner** 81 Roberts Way, North East Ceci1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🕅 F Yrs. Director October 16,1917 Pennsylvania 86 208 05 3719 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show freumatic event, the Madical Examiner must be natified at 1 ☐ Yes 2 X No Director Maryland Cecil North East 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? 21901 81 Roberts Way Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Harvey B Miller Catherine B Stiffler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Smith/Daughter 79 Roberts Way, North East, Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Importent: If Ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Rose Bank Cemetery Oct. 6,2004 Rising Sun, Maryland *4 □Donation 5 □Other (Specify)

1. Signatur = Turneral Service (icensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Primary Immediate Cause (Final Physician Cardiomy & Dorthy disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ATHEROSCIE ERDSIS OR OWARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed hysician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 SNo Day Year Month 4 Pregnant at time of death 5 Other (specify) P.0. the Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s has autopsy certificate 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 lo P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide in 24 hours.
the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00058354 Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCKING M.S. 101 COLONIAL Way, Rising Sun, MD 21911 39. Registrar's Signature 31. Date filed (Month, Day, Year) 5 2004 Grand March OCT Registrar

		•	For Stete Registrar	State	of Marylar	•	artment of H			•	giene Rog. No.?	nni.	37091	
			1. Decedent's Name (First, Middl	e, Last)						2. Date of De Month		Voca	3. Time of Death	
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,	Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location of	of Death		4c. Co	unty of Death		
Œ.				68 Bridge			North					Ced		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗖 F	7. Age (in yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	v. Year)	9. Birth	place (State or Foreigntry) Th Carolin	วูก
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside City Limit	s
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	the t	Directo	10e. Street and Number	CCII	1		10f. Zip Code	ппаз			10a. Citizen	n of What Cou	ntry?	
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0	or Ital	교	1 Never Married 2 Mar	ried Armed F	2 No	1			n, Puerto	Rican, etc.)		Black, White,	etc.	
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			30. Name and address of person	who completed car	se of death (Ite	m 23a) (Type	Print)	/_/	//	/	100	-/-/	-007	
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		Decedent's Name (First, Middle, Last)		ertificate of De		of Deeth	3. Time of Death
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H		Garrett County Memori 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	ff Under 1 Year If	Oakland Under 24 Hrs. 8. Date	of Birth	9. Birthplace (State or Foreign
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	ylenc	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
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a	B E B W	Nelson	Sanders	, ,	Vally		Paulie
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<u>8</u>	475 416 416 416 416 416 416 416 416 416 416	Margaret Sanders/wife	131	B Maffett La	ne. Oakland	. Ma. 21550)
ā,	- I S 5	20a. Method of Disposition	20b. Place of Dis	sposition (Name of rematory or other place)	Date		City or Town, State
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aitimor	# 분 년 글 ·	21. Signature of Funeral Service Licensee		22. Name and Address of	f Facility	04 Caktan	id, Halyland
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	icete be executed physician and s the bunial-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate	Due to (or es e cons	sequence of):			
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	in 24 hour in 24 hour he Funera pletely fill edical	29a. Certifier 1X Certifying Physician: To	the best of my knowledge, de ne besis of examination and/or	ath occurred at the time, d	date and place, and due to	o the cause(s) and ma	nner as stated.
	To the Hospital or Attending Physical within 24 hours stored death. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To	one) and	anner stated.				
	With With To I	29b. Signature and title of certifier	100	29c. License nu	mper		i (Month, Day, Year)
•		P 1 3	, , , ,		5333	10-07-2	JU4
		30. Name and address of person who completed of				1.550	
		Thomas G. Johnson M.	D. 311 N. FOL 2. Registrar's Signature	irth St., Oal	kland, Md. 2	21550	
	State	31. Dete filed (Month Year) 8 2004	L. Jegistiai 3 Signature	A 10.			

DHMH 16 Rev 6/95

			For State	of Maryland / Depa			1ental Hygie	ene	
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of D	eath	Reg	. No.	32986
	Physic		John Milton Schneider				Month Sept	27 2004	3. Time of Death 1704 M
>	/Medi Examir		4a. Facility Name (If not institution, give street and no	ımber)	4b. City, Town, or L	ocation of Death	DOPC	4c. County of Death	1704
			Carroll Hospital Center			inster		Carro]	.1
4	Funeral Director		5. Social Security Number 6. Sex 213-28-1238 1 M 2 F	7. Age (In yrs. last birthday) 72 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Cou	place (State or Foreign MD)
	put		Usual Residence of Decedent 10a. State 10b. County	100 Cit. T-					
	Maryla f shor	ō		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-	Director	MD Carroll 10e. Street and Number	Syke	sville		100	. Citizen of What Cou	
	th with	alD	7200 Third Avenue			21784	1.49	USA	my:
900	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "neturel", or items 23a or 28a-1 show od other then "neturel", or item? I ust be neitlied at event, the Midral Eximiter it ust be neitlied at	by Funeral	Armed F	2 No	Was Decedent of Hisp if Yes, specify Cuban, 1 ☐ Yes 2 ☐ No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	I within 72 h iene. r then "netu ihe Modical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College ((Give life. I	dent's Usual Occupati kind of work done dur DO NOT use retired) ract Admir	ring most of worki	ng C	b. Kind of Business/In ontrol Dat Corporatio	a ´
land	should be filed within nd Mental Hygiene. i marked other then umatic event, the M	To Be C	17. Father's Name (First, Middle, Last) John Z. Schneider				(First, Middle, Mai		
	har har 7 is		19a. Informant's Name/Relationship (Type, Print) James Schneider/brother					ity or Town, State, Zip	
Baltimore,	of Hei		20a. Method of Disposition 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo-	sition (Name of	D	ate 20c	E. Location - City or To Hampstead,	wn, State
Baltii	permit. Page Department of Importent: if eny injury of		21. Signature of Funeral Service-licensee		ritts fune	rai Home	and Char	pel, P.A.	
			23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause on a	caused the death. Do not ente	12 Washing or the mode of dying,	such as cardiac o	r respiratory arrest,	ster, MD	21157 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		elipathy				Interval Between Opset and Death
	Examiner	er	Sequentially list conditions. b	(or as a consequence of); (or as a consequence of);	interction				Days
	xecuted and Il-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of):	n Dispuse			Į.	lear
08/PN	ficate be executed physician and as the burial-transit	edical E	d						
. Box	death cert e attending d for use a	Physician/Me	in the past 12 months?	ant at time of death 5 🗌	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
rds, r	quires that in signed build be det	by	Part II. Other significant conditions contributing to de	eath but not resulting in the un	derlying cause given i	in Part I.	23e. Did tobacc	co use contribute to the	
	2 2 2	Completed	`				24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
\ \ \	sicien certifi rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	*	Other	6. Place of Death	-		
5	Phys or this oral dii	\vdash	1 ☐ Yes 2 No Hospital. 27. Manner of Death 28a. Late 6	npatient 2 ER/Outpatient of Injury 28b. Time of			e 5 Residence	6 Other (Specify,	
5	nding F ath. r: After e funera	atlor		h, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes	2 No	od. Describe flow in	njury occurred	
	after des after des Director d in by th	Certification;	3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm, stre ng, etc. (Specify)	et, factory, office	28	Bf. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying Physician: To the based mann	best of my knowledge, death asis of examination and/or investor	occurred at the time, of estigation, in my opinion	date and place, ar	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ted. the cause(s)
	M Veithir Vointh	Me	29b. Signature and title of certifier	mo	29c. License nu			Date signed (Month, D	
	الوا		30. Name and address of person who completed caus	1410	. / .	الم الم	A (20)	18/0-47, A	A 942/
•.	Stat	е	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signature	russ (thr	JLA DIJA	4 KKIST	13/0-47 /1	111 1111
	Registra	ır	SED 9 9 2004	K. L	1 .				

			1 - For State Registrar		aryland / Depa	artment of I rtificate of			Reg. No.	04	32987
	Physici /Medi		1. Decedent's Name (First, Middle, Last, Rober F		wingle			2. Date of De Month	Day 28	Year 04	3. Time of Death 5:45 P M
	Examir		4a. Facility Name (If not institution, give	street and number)	J	4b. City, Town, Annapo		eath		nty of Death Arun	d e1
	Funeral Director		5. Social Security Number 6. Security Number 187–22–2913 Usual Residence of Decedent	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi (Month, Di DEC . 1	oth av, Year) 0, 1928	9. Birthp Coul Penn	place (State or Foreign ntry) sylvania
	the Maryland 28a-f show ciffical at	Director	10a. State 10b. County Maryl and Anne Aru 10e. Street and Number	nd el	10c. City, Town or Lo	A	nnapoli		I	1	10d. Inside City Limits 1224 Yes 2 □ No
	Mith Ba or	١	106 Cypress Road			10f. Zip Code 21403			10g. Citizen o		*
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "neturel", or items 23a or 28a-1 show or other treumetic event, the Marical Examinant be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent E Amed Forces? 1XXYes 2 N If Yes, Give Year or Dates:	0 1946-			? (Specify Yes or No uerto Rican, etc.)	0- 14. R B	ace - Americ lack, White, cify: Whi	can Indian, etc.
Maryland 21215-0036	within 72 ho iene. 'than "netur Ire Madical I	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retire Chef	during most of	working	16b. Kind of	Business/In	dustry
land 2	should be filed and Mental Hygic marked other umetic event, II	To Be Co	17. Father's Name (First, Middle, Last) Colin R. Swingle			Olle1		Name (First, Middle	, Maiden Surn		
	and 2 shou ealth and M n 27 is mar		19a. Informant's Name/Relationship (Ty Jessie Sue Swingle			ng Address (Street	and Number or	nn apolis,	er, City or Tow		7 Code) 1403
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 i eny injury or other tre once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F ↑4 □ Donation 5 □ Other (Specify)	lemoval from State	20b. Place of Disponsion Crownsvil	natory or other pla		Date / 1 / 2 0 0 / 1	20c. Location	•	
Baltir	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licent)	22	. Name and Addre	ess of Facility	John M.	Taylor	Funer	al Home, In
	cate be executed / Medical	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	Due to (or as a	θ.		ng, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
O. Box 68760,	death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		(4)	ate of delive	ery Day Year
rds, P	gned be de	by	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the u	nderlying cause gr	ven in Part I.		obacco use co Yes 2 No	_	ne cause of death?
Vital Record	The law ate has b page 2 st	Completed						24a. Was auto perfo		prior to cor death?	psy findings available inpletion of cause of 2 No
of	ding Physicien: T h. After this certificat funeral director, pa	To Be	25. Was case referred to medicat examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 ☐ Inpatier 28a. Date of Injury (Month, Day	28b. Time of	28c. Injur Wor	er: 4 🗆 Nursin	Death (Check only of g Home 5 X Residence 28d. Describe	dence 6 🗆 Ot		/)
Division	tal or Attending s after death. I Director: After ad in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ry - At home, farm, str. (Specify)	eet, factory, office		28f. Location (S City or Tox		ber or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	sician: To the best of ner: On the basis of and manner stat	f my knowledge, death examination and/or inved.	occurred at the tire restigation, in my c	ne, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and m date and place	nanner as st , and due to	ated. the cause(s)
)	To the within 2 To the complete	W	29b. Signature and title of certifier L. Kemme	MMD		29c. Licens			29d. Date sign		
			30. Name and address of person who co	nmer,	ath (Item 23a) (Type, 900 Best	Egate R	d # 30	o, Ann	apolis	, M	04 D2140/
	Sta Registr		31. Date filed (Month, Day Year) 0 2	004 Strain	er &	1			,	,	

				partment of Health and Mertificate of Death		the the second	04000
		, 1	1. Decedent's Name (First, Middle, Last)	Timodic of Bodin	2. Date of Death	g. No.	3. Time of Death
	Physic /Med		LAURA LORRAINE	SMITH	Month	Day Y	ear
>	Exami			4b. City, Town, or Location of Death	2011.	4c. County of	04 10.33
			Pendun Regional Modery Center	SAUSBUM			um co
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth	9	. Birthplace (State or Foreign
	Director		220-01-7264 1□M 2ÅF 89 Yrs.	Months Days Hours Min.	June 16,	1915	Country) Virginia
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	conting			
	daryl f sho	ō	is a significant of the signific	LOCATION			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the f	rect	Maryland Wicomico Fruitland 10e. Street and Number	10/7:- 0-4-			
	ours after death with the Manylan rel', or Items 23a or 28a-f show Exaciliter: NSI Ee notified at	Funeral Director	413 Cartwright Avenue	10f. Zip Code 21826	10	g. Citizen of Wha	at Country?
	death ms 2;	era	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spe	offy Voc or No	USA	A second section of the section of the
(0	ffer (필	Armed Forces? 1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)		American Indian, White, etc.
03	rel', c	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No Specify:		Specify:	Black
215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-f show re M-dical Ex. :ilret". wat be notified at	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	1/	6b. Kind of Busin	
2	ithin Ne.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	ng		·
21	filled w Hygier Ither th		7th labo	rer	I	Domestic	
and	to be fi	Be	17. Father's Name (First, Middle, Last) Charles Smith	18. Mother's Name	(First, Middle, Ma	aiden Surname)	
Maryland	ges 1 and 2 should be filed within 72 hc at of Health and Mental Hygiene. If item 27 is marked other than "netun or other treumatic event, the Medical	2		Robert			unknown
Ma	d2s than t7 is i			ing Address (Street and Number or Rural			
	permit. Pages 1 and 2 Department of Health Important: If item 27 i sny injury or other tre ange.		20a. Method of Disposition 20b. Place of Disp	2 Pecan Drive - Printer of Printe		ne, Mary Dc. Location - City	
υO	Pages nent of l int: If it		1 Burial 2 □ Cremation 3 □ Removal from State Cemetery, cre	matory or other place)			•
Baltimore,	permit. Page Department Important: If eny injury o	-	21. Signature of Funeral Service Licensee	's Ch. Cem. 10/02/	2004 Pr	incess A	nne, Maryland
ñ	permi Depar Impo eny ir		1	2. Name and Address of Facility 121 DLLEY MEMORIAL C	A DEISEA	Road -	Salisbury, MD 21801
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause of each line.			t.	Approximate
	Pnysician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or is a consequence of):	Pneumonia			
	Examiner		Sequentially list conditions by Sept. S				
	₽ ∉	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	act Infetz	The contract of		
60,	cate be executed physician and the burial-transit	E	Due to (or as a consequace of):	materia.			
68760,		dical	d. C. Difficilla	COUTIS			
_	death certific e attending p id for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				32
Вох	atten for u	ician/M	in the past 12 months?	Ectopic pregnancy		23d. Date of Month	delivery Day Year
o.	0 0 0	Physi	1 Yes 2 No 4 Pregnant at time of death 5 g Unknown 9 Unknown	Other (specify)			,
S, P	the Beat	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Rart I.	23e. Did tobac	co use contribute	e to the cause of death?
rds	quires in signi uld be		Severe Dementia Aust	e Renal failure	1 ☐ Yes	L .	Probably 4 Dunknown
Record	> 0 0	olet	Congestive Heart falliers	De has been born	24a. Was an	24h Were	autopsy findings available
æ	е <u>г</u> е	Completed	justice)	nyaration	autopsy performe	d? prior	to completion of cause of
Vital	i cian : Th certificate ector, pag	Ø.	25. Was case referred to medical	26. Place of Death /		No 1 Y	es 2□No
of V	S 0 = 0	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient	04		e 6 Other /S	necifu)
	ding Phy h. After thi funeral o		27. Manner of Death 1 № Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time o Injury		d. Describe how		респу
sio	Attending ir death. ector: After by the fune	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	l or Atten after deatl Director: I in by the	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28	f. Location (Stree City or Town, S	t and Number or State)	Rural Route Number,
	Hospitel 24 hours a Funerel [tely filled	0	One Contiller				
	Hos 24 hc Fun etely 1	edical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one Check one Check only one Check one Check one Check one Check one Check one Check o	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	d due to the caus at the time, date	e(s) and manner and place, and d	as stated. lue to the cause(s)
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Me	29b. Signature and title of celtifier	29c. License number		Date signed (Mo	
	-> PO		1/////////////////////////////////////				,
6		1	30. Name and address of person who completed cause of death (Item 23a) (Type,	50060225		7-27	-04
Q			Steven Hamlette M. D IMF/	D0060225 arroll St. Sali	chier	MO-	2/80/
r	Sta	W.	31. Date filed (Month Pay, Year) 2004 32. Registrar's Signature	1	swig,	11111 0	1001
E.	Registr	ar	001 0 ± 2004	sporks			

320-01-7364

Laura Smith

DHMH 17 Rev 1/2001

Registrar

OCT 0 4 2004

			1 - For State Registrar		Maryland		artment of F		Mental Hyg	giene	32991
19.00	Physic /Medi		1. Decedent's Name (First, Middle	TR	AUB				2. Date of Deal Month OUTO BEI	Day Year	
	Exami	ner	4a. Fecility Name (If not institution HEBREW HOME OF 5. Social Security Number	GREATER W	ASHINGTO		4b. City, Town, o	ILLE		4c. County of Dea	IERY
	Funeral Director		084-05-5010 Usual Residence of Decedent	1 M 2 F	7. Age (In yrs. Ia:	Yrs.	Months Days	Hours Min	n. (Month, Day,		rthplace (State or Foreign country)
	e Marylan 8e-f show tiffed et	ctor	10a. State 10b. County MARYLAND MONT	GOMERY	10c. City,	ROCK					10d. Inside City Limits 1 Yes 2 No
	ath with the 23e or 28	rai Director	10e. Street and Number 6121 MONTROSE	ROAD				0852	UN	og. Citizen of What CITED STATE	country? S OF AMERICA
9600	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or Items 23s or 28e-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ▼Widowed 4 □ Divorced	Armed Ford	2 ₹ No		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	filed within 72 h Hygiene. other than "nati ent, II a Medica	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1.2	t grade completed) College (1-4		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w d)	orking	16b. Kind of Business OWN HOM	,
Maryland	should be filed ind Mental Hygi s marked other umatic event, I	To Be	17. Father's Name (First, Middle, 1) JULIUS MILLS 19a. Informant's Name/Relations!	STEIN		401-14-11		FANN	ame (First, Middle, M	TH	
	t Health an tem 27 Is:		JUDITH KAY - DA 20a. Method of Disposition		20b. Plac	1437	LONGHILL	DRIVE,	POTOMAC,	City or Town, State, MD 20854 20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury organer traumatic evonce.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I	necify)	late	EAN ME		ardens 1 ss gotd bef	.0/04/04 RG MEMORIA	OLNEY, M	ARYLAND INC.
	Physician /Medical Examiner		23a. Part Linter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. 5	used the death. ch line.	5	1170 ROC	KVILLE I	CIKE, ROCK	CVILLE, MD	2085 2 Approximate Interval Between Onset and Death
8760,	ę	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	c	r as a consequer						
.O. Box 6	the death certific y the attending p ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		th 2 Fetal de nt at time of deat	eath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P.	The law requires that ite has been signed b rage 2 should be deta	þ	Part II. Other significant condition SENILE	DEME	th but not resultin	ng in the ur	derlying cause give	en in Part I.		acco use contribute to	A -
of Vital Records,	<i>c</i> 0 <u> </u>	Completed	OF Management						24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of
Division of Vit	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig.	28a. Date of (Month,		VOutpatient Bb. Time of Injury	3 DOA Othe 28c. Injury Work M 1 1	or: 4 Nursing I	ath (Check only one Home 5 Resider 28d. Describe hov	nce 6 Other (Spec	cify)
Divis	Hospitel or Att 14 hours after de Funeral Direct tely filled in by t	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 286. Place of building	f Injury - At home _{I,} etc. <i>(Specify)</i>				City or Town,	,	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the be xaminer: On the basi and manner	is of examination	edge, death n and/or inv	estigation, in my op	death occi	irred at the time, dat	use(s) and manner as te and place, and due	to the cause(s)
	F 3 F 8		· paubour	Lolox	eng 1	1.D.	29c. License		6 00	d. Date signed (Mont)	03, 2004 03, 2004
S	Sta	te.	30. Name and address of person we have been addressed by the person we have been addressed by the person we have been addressed by the person we have been addressed by the person of the	ala Zui	1 6 / 2	2/1	ONTED.	SE ROAL	2. ROCKV	ILLE, HI	020852
	Registr		OCT 04	2004	equipment .	19	Sparks				

			1 - For State Registrar	State of Maryla		artment of H			ene	1. 32002
			Decedent's Name (First, Middle, Last	st)				2. Date of Death		3. Time of Death
	Physici					Thompso	2.0	Month October	•	Year M
2)	/Medic		4a. Facility Name (If not institution, give		trude		Location of Death		4c. County of	
	Examin	er	13923 Craddock				esaptown			•
	Francial		5. Social Security Number 6. S		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,)	AI	1egany 9. Birthplace (State or Foreign Country)
н	Funeral Director			□M 2□XF 90	Yrs.	Months Days	Hours Min.	(Month, Day,) 01/05/19	(ear) 914	Country) West Virginia
			Usual Residence of Decedent							
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Man 4 st	ξ	MD Alleg	anv	Cre	saptown				1 ☐ Yes 2XXVo
	1 the	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wh	nat Country?
	3a out		13923 Craddock	Road		21	502		USA .	
	ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in I	J.S. 13. \	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race -	- American Indian,
(0	r ita	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No				Hican, etc.)		White, etc.
ဗ္ဗ	urs a	à	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 2☒ No	Specify:		Specity:	White
9	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show the Madisal Examinar must be notified at	Completed	15. Decedent's Ed		16a. Deced	ient's Usual Occupa kind of work done d	ition	16	6b. Kind of Busi	ness/Industry
7	hin 7	pie	(Specify only highest gra	College (1-4or 5+)	life. I	DO NOT use retired,	ling most of wor	Wing		
2	d wit	ĕ	12			0wner_			Food N	Market
Þ	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or itams 23a or 28e-f show or event, the Madisal Examinat must be notified at	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
Maryland 21215-0036	2 should be and Mental is markad o	To B	Richard	Henry	V	right	Mary		R	ider
ary	es 1 and 2 should b of Health and Ment f itam 27 is marked ir other traumatic e		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Rui	al Route Number, (City or Town, St	ate, Zip Code)
	nd 2 alth a 27 ls		JoAnna Skelley/da	ughter	1261	5 Valley	View Ave	enue, Cres	saptown	, MD 21502
<u>6</u>	s 1 a f Hei itam othe	1	20a. Method of Disposition	I .	Place of Dispo	sition (Name of natory or other place		Date 20	c. Location - Ci	ity or Town, State
Baltimore,	permit. Pages Department of I Important: If its any Injury or of once.		1\\(\)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		•	•	· 1	6/2004 1	7 1 -1	.1 1117
₫	artm ortar lojur		21. Signature / Funer I Service Licer	, , A	22	. Name and Addres	s of Facility Ada	ms Family	Funera	al Home, P.A.
Ba	Depar Impo any Ir		11.40	allen				et, Cumbé		17.7
			23a. Part1. Enter the disease, or com	olications that caused the dea	th. Do not ent				<u>`</u>	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1.1	1	1			Interval Between Inset and Death
н	Physician /Medical		disease or condition resulting in death)	a. 11/6/195	TATIC	Ling	CH	ncer		Comos
	Examiner			Due to (or as a conse	quence ot):	1				
		-	Sequentially list conditions,	b Due to (or as a conse	mence of).					
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (0. 40 4 00.00	4401100 017	•				
	and I-trar	xan	that initiated events resulting in death) Last	cDue to (or as a conse	Quence of):					
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit		ı		,					
87	cate phys the	dicai	•	. d						
9 ×	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancv					
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet	aldeath 3□	Ectopic pregnancy			23d. Date of Month	
o.	the a	/sic	1 □ Yes 2 ☒ No 9 □ Unknown	4 Pregnant at time of 9 Unknown	death 5∟	Other (specify)				
P.O.	that the de led by the a detached t	Phy	Part II. Other significant conditions c	natributing to death but not re	culting in the ur	adarhina agusa awa	n in Part I	23e Did tohar	cco use contribu	ute to the cause of death?
	se Log	by	ratti. Other significant conditions o	orninouting to death out not re	saming an are ar	idenying cause give	11 411 4111.	1 ☐ Yes	1	☐ Probably 4 ☐Unknown
Records,	w requir been si should	ted						10.00	27.00	
Ö	e law has b	pje						24a. Was an autopsy	prio	ore autopsy findings available or to completion of cause of
		Completed						performe 1 ☐ Yes 2 💽		ath?]Yes 2□ No
ita	Physicien: T this certificat ral director, pa	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
>	ysic ais ce dire	10	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA Othe	r: 4 Nursing Ho	ome 5XXResidenc	e 6 Other	(Specify)
٥ ر	ig Pt ter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred	
Ö	Attanding r death. ector: After by the fune	atic	2 Accident investigation		,,		es 2 🗆 No			
Division of Vital	Atta	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (Stree City or Town, 5		or Rural Route Number,
ā	tel or Attanding Physic s after death. al Director: After this or ed in by the funeral dire	Certification;		building, etc. (open	.97			ony or rount, o	olato,	
	Hospitel		29a. Certifier tX KCertifying Ph	ysician: To the best of my kn	owledge, death	occurred at the time	e, date and place,	and due to the caus	se(s) and mann	er as stated.
	To the Hospitel or At within 24 hours after or To tha Funaral Direct completely filled in by	ledicai	(Check only 2 Medical Exam	niner: On the basis of examin and manner stated.	auon and/or inv	esugation, in my op	mion, death occur	ed at the time, date	and place, and	uue to the cause(s)
	withir To the Comp	ž	29b. Signature and title of certifier	. / 101		29c. License	number	29d	. Date signed (Month, Day, Year)
	4		· YHI	Danel V	m	D22	181	0	ctober)	4, 2004
	(, /		30. Name and address of person who	completed cause of death (lite	m 23a) (Type, I	Print)				
	Thas		Gary L. Wagone	//		Walsh Dr	ive, Cum	berland	MD 215	502
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign		,				
	Registr		OCT 0 4 200	14 mores	D	Sparks	/			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** 345 PM SUSAN 04 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UMMS Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 M 2 F 217-58-8728 52 Yrs. Director Maryland 3/17/52 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked othar than "natural", or items 23a or 28a-f ahow other traumatic avent, the Medical Examinar must be notified at Abendeen 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 759 Cronin Drive 21001 **HSA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 1 and 2 should be filed within. Health and Mental Hygiene. em 27 is marked other then ". Elementary/Secondary (0-12) College (1-4or 5+) 5+ Administrator Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Julius Archer Ringgold Clara Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if item 27 is. any injury or other trau. Macon L. Tucker / husband 759 Cronin Drive, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grds. 10/9/04 Aberdeen, Maryland 22. Name and Address of Facility
Lisa Scott Funeral Home, P.A.
552 Lewis Street, Havre de Grace, 21. Signature of Funeral Service Licensee MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intaceretral Hemorinae **Physician** /Medical Due to (or as a consequence of) Examiner 10 days Sequentially list conditions, any, learning to min ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consecuence of ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 7No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **X** No 3□ DOA filled in by the funeral dir ů 1 patient 2 ER/Outpatient this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours e To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) at AU 4176435B15983 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Univ of MD. ZZ S. Greene St. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 4004 Registrar

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 4 3 2 9 9 L	-					
No.	Physici /Medi		Charlette Tyles September 25 2004 0 13.	M					
	Examir	ner	4a. Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Death Ac. County of Death Northwest Hospital Center S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore)						
	Funeral Director		5. Social Security Number 6. Sex 1 I M 2DF 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 2 1 1 / 25 / 1930 9. Birthplace (State or Foreing Country) MARYIJAND	ign					
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit MD CARROLL WESTMINSTER 1 □ Yes ※□ N						
	with the	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 HUMBERT SCHOOLHOUSE RD. 21158 USA						
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28s-f show any Injury or other traumatic event, the Medical Examplant must be invitified at ance.	by Funeral Director	11. Marital Status 1						
21215-0036	within 72 ho lene than "natur the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE HOMEMAKER						
Maryland 2	ould be filed Mental Hygi arked other attc event, t	To Be Co	17. Father's Name (First, Middle, Last) GEORGE ERNEST DIMICK 18. Mother's Name (First, Middle, Maiden Surname) ADELINE WOOLSLAGHER						
	and 2 sho salth and n 27 is mu		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21158 720 HUMBERT SCHOOLHOUSE RD., WESTMINSTER, MD						
Baltimore,	Pages 1 ment of Ha ant: If Itan ury or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State						
Balt	permit. Depart Import any Inj		21. Ignature of Funy at Service Obensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157						
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):						
8760,	ate be executed hysician and the burial-transit	ai Examiner	Sequentially list conditions, it any, reading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):						
.O. Box 687	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year						
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration pneumonia // Sick sinus syndrome 1 Yes 2 No 3 Probably 4 Unknown						
Record	The law re ate has be page 2 sho	Completed	Acute reral failure / Chronic obstructive pulmunary 1584 34a. Was an autopsy performed? Type II disabetes mellitus / Gastroes consured return disease 1 yes 20 No 1 yes 20 No	le					
Viital	rsician: Th s certificate firector, pag	o Be	25 Was case referred to medical examiner? 1 Yes 2 No						
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his complately filled in by the funeral director, page	1-1	27. Manyler of Death 1 Watural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mr. 28c. Injury at Work? 1 Work? 2 Accident 1 Yes 2 No						
Divis	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After complately filled in by the funer	Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	Ī					
	To the Hospital or within 24 hours after To the Funeral Direction complately filled in I	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	WJL	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 28462 September 25, 2004	ł					
	4		30. Name and address of person who completed cause of death (Item 23a) (Type. Print) 5401 of Gourt 604 J Boston Northwest Hospital Center Randalls Town, Maryland 21133						
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registar's Signature						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2, P M October 0 Maria de los Angeles Vasquez 2004 4:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3474 Bantry Way Olney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye August 1, 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2182 F 87 Yrs. **1**917 Guatemala Director 215-06-9242 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itama 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery 01ney 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3474 Bantry Way 20832 Guatemala death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene Important: If itam 27 is marked other than "natural", or Itan any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 t√x Yes 2□ No Specify: Guatemalan Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rafael Vasquez Maria Teresa Castillo 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 East D Street; Brunswick, MD 21716 Maria Fritter / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 9, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Resthaven Mem. Gardens 21. Signature of Fuseral Section 120 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatic Encephalopathy Days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine requires that the death certificate be executed the burial-transit Due to (or as a consequence of): the attending physician hed for use as the buria P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2/3 No or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funaral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel 29a. Certifier 1🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0055694 October 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alok Mathur, M.D. 4000 Olney-Laytonsville Rd. Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sener oaks Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death oct 3,2004 Year **Physician** 8:21 P /Medical Helen Victoria Wright 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 2 € F Director 226-52-9329 Virginia Usual Residence of Decedent tha Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Evainmer must be notified at X□Yes 2□No Director MD Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 419 Lincoln Ave. 20912 Completed by Funeral UsA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other then "natural, or iter Aimed Folces! 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 27 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Queen Victoria Perkins ္ garland P. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 sh Department of Health and Important: if Item 27 is m any injury or other traum <u>once.</u> Mollie Jean Holmes - Sister 3209 Jeter Ave Richmond, VA 23222

20a. Method of Disposition (Name of Commeter, crematory or other place)

15 Burial 2 Cremation 3 Depreyal from State Commeter, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Antioch Bapt Ch. Cem 10/8/04 Skippers, VA. 21. Signature of Funeral Service License 22. Name and Address of Facility Knox-High Mortuary, Inc. 568 Halifax St. Emporia, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a conseq Examiner mulmonia Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown cate has been signed by I page 2 should be detact Part II. Other significant conditions contributing a death burn of resulting in the upper ingicau a given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 🗷 No 1 Yas the Hospital or Attending Physicien: nin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 KNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carroll Ave Takoma Park Md. Nasroon Kango 31. Date filed (Month, Day, Year) State Elden & Sparke OCT 0 5 2004 Registrar

				For State Registrar	State of Ma	ryland	-	artment <i>tificate</i>			nd Men		ene	04	32997
	1	Physici /Medi		1. Decedent's Name (First, Middle, Las Genevieve E. War	*						1	Date of Death Month tober	Day	Year 04	3. Time of Death 10:39 A ^M
	1	Examir	ner	4a. Facility Name (If not institution, gived Ft. Washington H. 5. Social Security Number 6. S	ospital	/In ure Is	nst birthday)		Was	ocation of hingt	con	nato of Disth			eorge
		Funeral Director			^{SX} M 2⊠F 82		Yrs.	Months	Days	Hours	Min. (/	ly 8,	Year) 1922_	Sale	place (State or Foreign ntry) M PA
		Marylande-febow	ctor	10a. State 10b. County MD Prince C			Town or Lo							The second secon	10d. Inside City Limits 1 XYes 2 □ No
		with the a or 28 Lbe no	Director	10e. Street and Number	ari rro			10f. Zip (Code 1745			10	g. Citizen of	What Cou	ntry?
	9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event. Its Medical Examinat rith the notified at ORCE.	Funeral	7212 Abbington D 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give		li li	Vas Decede	ent of Hisp fy Cuban,	oanic Origin Mexican, I	n? (Specify Puerto Ricar	Yes or No- n, etc.)	Bla	ack, White,	
	5-003	72 hours "natural",	leted by	3 XWidowed 4 ☐ Divorced 15. Decedent's Ec (Specify only highest gra	Year or Dates:		16a. Deced		Occupati	on	of working	11	6b. Kind of E	Business/Ir	
	2121	d within giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		e retirea)		=	Α.	Domes	stic	
	Baltimore, Maryland 21215-0036	ould be file Mental Hy arked other atic event.	To Be	17. Father's Name (First, Middle, Last) Samuel Blakey					1		s Name (Firs	st, Middle, Ma eeney	aiden Suma	me)	
	Man	d 2 sho th and I		19a. Informant's Name/Relationship (ute Number, (n Hill	-		Code)
	ore,	es 1 an of Heal fitem 2 r other		Bethesda Alexand 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □		20b. Pla	ace of Dispos metery, crem	sition (Name	e of	OII DE	Date		oc. Location		own, State
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		Physician /Medical Examiner		23a. Part1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the cause on each line a.	١.		er the mode	of dyin <i>g</i> ,	such as ca	ardiac or res	piratory arres	it,		Approximate Interval Between Onset and Death
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(1)		ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, juisgase or injury	Due to (or as a	conseque	ence of):								
1317	8760,	ficate be executed physician and is the burial-transit	dical Examiner	that initiated events resulting in death) Last	c	conseque	ence of):								
ENE	.O. Box 6	a death certi he attending ted for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3 🗌	Ectopic pre Other (spe						ate of deliver	ery Day Year
), G	S,	quires that the n signed by t and be detach	by	Part II. Other significant conditions of	ontributing to death but	not resul	ting in the un	derlying cau	use given	in Part I.	2	23e. Did toba 1 ☐ Yes		tribute to th	he cause of death?
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3	Vital		Be	25. Was case referred to medical examiner?	Hospital:		2/0		Other			ack only one)		-	
	of	ding h. After fune	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		R/Outpatient 28b. Time of Injury		c. Injury a Work?		28d. [5 Resident Describe how			y)
	Division	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: Attecompletely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At hon (Specify)	ne, farm, stre	et, factory,	office		28f. L	ocation (Stre	et and Numi State)	ber or Rura	d Route Number,
		Mospi 24 hour Funer etely fill	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of liner: On the basis of e and manner state	xaminatio	ledge, death on and/or inv	occurred at estigation, i	t the time, n my opin	date and p ion, death	place, and di occurred at	ue to the cau the time, date	se(s) and m and place,	anner as s and due to	tated. the cause(s)
_		To the within To the compl	Me	29b. Signature and title of certifier	1.4.0			29c.	License n	umber	200	290	. Date signe	ed (Month,	Day, Year)
•	,			30. Name and address of person who		ith (Item :	23a) (Type F	Print)	700	1,20	6 TT	+11	0/2	100	1.
(Cf	-(5)		SUBASHRIS, RE	DOY, MO	1170	ol LIV		CIOI	RDS	SUITED	1, FTu	ASHIN	15731	1, MO 2074
0		Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar	s Signatu	erie de la companya della companya della companya de la companya della companya d	9.				,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Amend Item 1 per Dr., G836, 10/28/20/48/bb Death 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary J. Wilkins Day **Physician** Month Year 6:05 AM OCTOBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 212 F 185-24-0559 71 Yrs Director JUNE 15,1933 READING Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "neturel", or Items 23a or 28a-f shov The Medical Examiner must be netified at 1 X Yes 2 □ No DELAWARE SUSSEX COUNTY MILLSBORO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 90 HUB COURT 19966 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry EDUCATION Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Importent: If item 27 is marked other tha any injury or other traumatic event, Insupple. PERSONNEL COORDINATOR 12 (COMMUNITY COLLEGE) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) STANLEY NOROCKI AGNES KOZIK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **GENE** WILKINS (HUSBAND) 90 HUB COURT; MILLSBORO, DELAWARE 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 10/4/2004 DELMAR, DELAWARE ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WATSON FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Elef only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Candidal SIX DAYS SEPSIS /Medical Due to (or as a consequence of): Examiner Candidal EIGHT DAYS peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit pancreatic p
Due to (or as a consequence of) pseudocvst FIVE WEEKS Box 68760 Physician/Medical as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ scleroderma/myusitis overlap syndrome 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Clustridium difficile autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 X Natural 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) angeline Chong, MEDICAL DOCTOR RES-000 OCTOBER 2,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angdine Chong, The Johns Hopkins Hospital, 600 North Welfe Street, Baltimore, Maryland 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

borde

32. Registrar's Signature

	Decedent's Name (First, Middle, Last,	State of Marylan 29d per Dr., G	Certificat	C OI DCatil	2. Dete of De	- / / /	1	Time of Death								
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wer must be notified Funeral Director		12. Was Decedent Ever in U, Armed Forces?		lent of Hispenic Origin?	Specify Yes or No		e - American Ir	ndian,								
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or other trau	Karen Sue Warren		8575 Leon	ardtown Roa	d Hughoes	rallo M	arul and	20637								
other traumatic event, the Medical Exe To Be Completed by	20a. Method of Disposition	20b. P	lace of Disposition (Name	ne of	Date	20c. Location -										
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DHMH 16 Rev 6/95

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar
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	Funeral Director		5. Social Security Number 172 34 6068 1 M 2 F 83 Yrs. Comber and Alleganger Alleganger Alleganger Alleganger Alleganger Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Country)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example that the be invitified at once.	To Be Completed by Funeral Director	10b. County 10c. City, Town or Location 10d. Inside City Limits 1 10d. Inside City Limits 1 10d. Inside City Limits 1 10d. Street and Number 194 Wable Dr. 15540 10g. Citizen of What Country? USA 15540 USA 10d. Ammed Forces? 1 10d. Zip Code 15540 USA 11d. Marital Status 1 2 2 2 2 2 2 2 2 2
. Box 68760,	in death certificate be executed the attending physician and the attending physician and the drouge as the burial-transit	Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to minimize a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a nsequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as
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Div	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Certif	4 Homicide building, etc. (Specify) 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
)	7. 2. 2.00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Tohn Mehana 902 Seton Drive Cumberland, MD 21502
ò	Sta Regist		31. Date filed (Month, Company) 8 200 32. Redistrar's Signature